WORKING TOGETHER TO MAKE THE CONNECTION
COUNCIL OF STATE NEUROSURGICAL SOCIETIES

THE NEW CSNS

ADDRESSING VOLATILE NEUROTRAUMA ISSUES FROM A GRASSROOTS PERSPECTIVE
CONTRAINDICATIONS
have been conducted with GLIADEL® Wafer. Carcinogenicity, mutagenicity and impairment of fertility studies have been conducted.

Primary Surgery

Therapeutic Interactions:

nursing infants, it is recommended that patients receiving GLIADEL® Wafer discontinue nursing.

Pregnancy:

There are no studies of GLIADEL® Wafer in pregnant women. If GLIADEL® Wafer is used during pregnancy, or if the patient increases embryo-fetal deaths, reduced numbers of litters, and reduced litter sizes.

INDICATIONS AND USAGE

BRIEF SUMMARY OF PRESCRIBING INFORMATION

8 mg/kg/week for eight weeks (about 1.3 times the recommended human dose on a mg/m² basis) in male rats.

PRECAUTIONS

A 2 cm diameter of a wafer exists, it should be closed prior to wafer implantation.

DIABETES MELLITUS

Nervous system

Microangiopathic changes in the brain may occur, resulting in a spectrum of cerebrovascular symptoms ranging from mild, transient ischemic attacks to frank stroke. If patients develop these symptoms, it is recommended that they discontinue therapy with GLIADEL® Wafer and have them evaluated by a specialist.

It is not known if either carmustine, carboxyphenoxypropionate, or sebacic acid is excreted in human milk.

Interactions of GLIADEL® Wafer with other drugs have not been formally evaluated.

PATIENTS RECEIVING GLIADEL® WAFER AT INITIAL SURGERY

COMMON ADVERSE EVENTS OBSERVED IN

5% OF (SCE assay in rodent brain tumors, mouse (Ames assay, human lymphoblast HGPRT

Nausea 26 (22) 20 (17)
Diarrhea 6 (5) 5 (4)
Constipation 23 (19) 14 (12)
Hemorrhage 8 (7) 7 (6)
Deep thrombophlebitis 12 (10) 11 (9)
Allergic reaction 2 (2) 6 (5)
Chest pain 6 (5) 0
Myasthenia 5 (4) 6 (5)
Grand mal convulsion 6 (5) 5 (4)
Dizziness 6 (5) 11 (9)
Abnormal gait 6 (5) 6 (5)
Paresthesia 7 (6) 10 (8)
Personality disorder 10 (8) 9 (8)
Speech disorder 13 (11) 10 (8)
Somnolence 13 (11) 18 (15)
Convulsion 40 (33) 45 (38)

In the initial surgery trial, the incidence of seizures was 33.3% in patients receiving GLIADEL® Wafer and 37.5% in patients treated with placebo.

In the initial surgery trial, the incidence of brain abscess or meningitis was 5% in patients treated with GLIADEL® Wafer and 0% in patients treated with placebo.

In the recurrent surgery trial, the incidence of brain abscess or meningitis was 4% in patients treated with GLIADEL® Wafer and 0% in patients treated with placebo.

The following post-operative adverse events were observed in 4% or more of the patients receiving GLIADEL® Wafer at recurrent surgery. The incidence of brain abscess or meningitis was 4% in patients treated with GLIADEL® Wafer and 0% in patients treated with placebo.

SANS Lifelong Learning is still the best tool to build your knowledge base through instant learner feedback, peer-reviewed expert critiques and web-based resources for further study. The improved features and enhanced functionality make SANS all the more valuable.

Score Summary & Analysis

Review your score and see how you compare with others who have taken the test. The analysis tool gives you the option of a quick overview of your overall SANS performance or a specific analysis by category. With expanded learning links and in-depth critique of each question, you maintain and improve your proficiency in surgical decision making. This new version of SANS Lifelong Learning also affords tracking of resident performance and downloadable, ACGME compatible reports.

Content

SANS content is updated to allow you to stay informed and up-to-date with the latest advancements in the field!

Welcome to the New Year! With this Winter 2009 issue, we are proud to assume the responsibility as the CNSQ editors. We are indebted to the Congress of Neurological Surgeons, its members, and particularly Ali Rezai, MD. It was through Dr. Ali Rezai’s leadership that Neurosurgery News was transformed from the traditional CNS newsletter into this quarterly journal. The CNSQ has become an outstanding publication and resource for the CNS members with the goals of educating and informing its members through a neurosurgical forum.

The CNSQ has been fortunate in relocating the editorial, production, and design to the CNS headquarters in Schaumburg, Illinois from the Neurosurgery News editorial office. April L. Booze, CNS Marketing Services Coordinator, Michele L. Lengerman, CNS Director of Marketing and Membership Services, and Laurie L. Behncke, CNS Executive Director, have been instrumental in this process and we would like to thank them for their tireless efforts in affecting a seamless transition. Paula Novash continues to assist with literature editing. Our new graphic design firm, Westbound Publications, has expertly enhanced the CNSQ’s already artistic and trendy appearance. We would also like to welcome and thank our new members to the CNSQ Editorial Board. These members include representatives from the Joint Sections, Washington Committee, the Council of State Neurosurgical Societies (CSNS), and Women in Neurosurgery (WINS) and will serve to enable these groups ability to highlight their activities for the general CNS membership. Lippincott, Williams and Wilkins continues to serve as publisher.

In this issue, we highlight the accomplishments of the Council of State Neurosurgical Societies. The CNS has evolved into a multifaceted organization that serves to educate and advocate for many important socioeconomic issues and has attracted many young neurosurgeons to help guide and implement their worthy agenda. The socioeconomic theme is continued in the Perspectives section through two compelling opinion pieces. In addition, there is a recap of the immensely successful 2008 CNS Annual Meeting in Orlando, Florida. President P. David Adelson and Immediate Past President Anthony Asher present a State of the CNS, which complements the annual Secretary’s and Treasurer’s Reports. Also, various CNS committee reports are presented in the Inside the CNS section, while the Reader’s Forum offers an update on Project Shunt, initially featured in our Summer 2008 humanitarian issue.

As we move forward in 2009, we will be presenting further issues of value and interest. The Spring issue will be dedicated to defining the neurosurgical “workforce”. All readers are encouraged to submit articles, images for our Images in Neurosurgery section and opinion pieces to info@1CNS.org. On behalf of the Editorial Board and staff of the Congress Quarterly, we wish all of our readers a healthy and happy 2009.
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The 2008 CNS Annual Meeting audience experiences innovative educational science during the 3-D Live Cadaveric Demonstration.
The Congress of Neurological Surgeons was founded by a group of visionary physicians in 1951 with the objective of “enhancing health and improving lives worldwide through the advancement of education and scientific exchange.” Over 57 years later, our organization has never been more ideally situated to realize their remarkable vision. Through a commitment to innovation, we have been able to consistently develop meaningful, relevant educational products while advancing the science of learning. Our investment in information technologies now allows us to provide our worldwide membership with instantaneous access to medical knowledge in a variety of meaningful formats. Our international outreach, now facilitated by advanced information technologies, has allowed us to effectively partner with neurosurgeons in the global community and promote the delivery of safe and efficacious neurosurgical care to patients the world over.

The CNS has been able to sustain its mission through the volunteer efforts of thousands of its members. It is because of this spirit of volunteerism and innovation that the CNS has been able to remain at the forefront of neurosurgical education, while maintaining its outstanding value as a professional society.

We are once again happy to report that the CNS is in an excellent state and continues to experience unprecedented growth and success.

Membership
Our membership committee is chaired by Dr. Russ Lonser. Under his leadership, membership has continued its steady growth. There are now over 6,200 CNS Members, including over 3000 Active members, over 800 International Members and just over 1,000 Resident Members. Currently the fastest growing area of CNS membership is our international membership and it is expected to grow further through our global efforts and outreach. The number of CNS International members has grown 35% over the past 5 years and over 20% since the 2007 launch of our International Vista membership category which, through electronic-only interaction, made the CNS membership and its benefits accessible worldwide. With the new medical student membership category, the CNS hopes to enhance early neurosurgical development and education. Dr. Lonser will be assisted this upcoming year by Dr. Catherine Mazzola to help develop the medical student and resident memberships.

Treasury
Dr. Joel MacDonald’s term as the CNS Treasurer came to an end at the Annual Meeting but he leaves with the financial picture of the CNS remaining robust. Total assets equal $17,634,815 with $12,929,876 held in the investment portfolio. The CNS Endowment for Fellowships and Education at $4,403,095 supports the numerous named lectures and fellowships of the society. The CNS Research and Development account was set up specifically to provide funds for the development of novel educational and innovative ideas that may occur outside the annual budget. The organization’s main sources of income include revenues from publications, the Annual Meeting, and dues. For over 6 years, active member dues have remained
unchanged at $335.00 annually, perhaps the lowest of any major medical organization. Dr. Daniel Resnick will capably succeed Dr. MacDonald as Treasurer for the term of 2008-2011. A detailed Treasurer’s report can be found on page 30.

Annual Meeting
The theme of this year’s Annual Meeting was The Community of Neurosurgery: Wisdom from Shared Experience. This theme reflects the imperative for all neurosurgeons to embrace new paradigms for clinical practice and continuing medical education in order to maintain our ability to effect positive change in healthcare. The collaborative “workshop of ideas” created for Orlando represents an important advance in our collective ability to navigate and master the tools of a knowledge-centered society.

Lessons from learning science informed the design of scientific sessions throughout the meeting, consistent with our organization’s commitment to developing relevant educational experiences and advancing the science of education. Interactive programs such as Integrated Medical Learning®, Consensus Sessions and Cases and Coffee with the Masters allowed the participants the opportunity to advance our collective understanding of current practice, evaluate its effectiveness and develop hypotheses for new avenues of investigation. Similarly, the invited speakers, particularly poet-activist Maya Angelou and the 2006 Nobel Peace prize winner Muhammad Yunus, amplified the essential messages of individual responsibility and collective potential.

The Annual Meeting and Scientific Program Committees were led by Drs. Gerald Rodts, Nathan Selden and Ali Rezai; they developed a unique and creative program that emphasized multiple innovative approaches in learning science that are beginning to transform educational systems around the world. This year’s meeting continued to build on the concept of “meeting as a laboratory” where each participant was a participant in the defining of consensus and knowledge for the field. Other highlights included the continuation and expansion of educational and scientific innovations introduced over the last four years, such as the Neurosurgical Forum, Select Abstract Sessions, Resident SANS Challenge, Digital Masters, and Live 3-D Demonstrations, and interactive subspecialty programs. This historic meeting was again made possible through the dedicated efforts of over 800 volunteers. The details about specific programs, the reviewed literature for IML, and speakers were highlighted in the Annual Meeting (Fall) issue of the CNSq in advance of the meeting.

Advocacy
Advocacy remains a very important concern for each professional society and the CNS continues to work diligently along with our colleagues in the AANS and our joint Washington Committee (WC) to address multiple issues that impact our neurological patients as well as our neurosurgeon members. A full enumeration of the multiple simultaneous cooperative advocacy initiatives and projects is beyond the scope of this summary and the CNS encourages all of our members to become involved with the process. As a small specialty, every volunteer and every effort makes a difference.

Evidence Based Medicine and Quality initiatives remain top priorities for regulatory agencies, insurance companies and legal entities. In order to preserve our ability as a specialty to define quality neurological care, the CNS, in partnership with the AANS, developed the Joint Guidelines Committee (JGC) and the Quality Improvement Workgroup (QIW). These two important sub-committees of the WC were created to ensure that neurosurgical practice and quality measures are guided by evidence, as opposed to “consensus” opinions of self interested groups with little supportive literature. The JGC under the leadership of Dr. Mark Linskey is one of the hardest working committees in organized neurosurgery. This committee has consistently and often with short notice evaluated numerous evidence based documents utilizing accepted standardized criteria, so as to develop new guidelines, recommend changes in text and terminology to the authors and/or make other recommendations to the CNS and AANS based on their findings. Whereas the Sections have been at the forefront of guidelines development over the years, many times in collaboration with other societies, the JGC was organized to allow representation of all of the subspecialties within neurosurgery in a framework that promotes rapid guideline development using a more standard, consistent approach. In an attempt to further refine the guidelines development process, a pilot partnership with a professional Evidence Based Practice Center (EPC) located at McMasters University was initiated this year in an attempt to “fast-track” a high priority practice guideline for the surgical management of brain metastases using a multidisciplinary group of authors. We look forward to their report at next year’s meeting in New Orleans.

The QIW, first under the leadership of Dr. Robert Harbaugh and now Dr. Daniel Resnick, has been tasked with ensuring that quality indicators being discussed and proposed for implementation by national quality agencies are applicable to neurological procedures and processes. Quality indicators with “purported utility and benefit” need to be based in evidence and must have demonstrable positive impact on outcomes measures, as opposed to process measures alone. While various governmental agencies and advisory councils continue to promote the implementation of pay for performance, neurosurgery has been the rational voice as to true cost benefit, outcome over process, and the practical impact of implementation. In response to various external calls for more quality data, and in order to advance our collective understanding of the value and effectiveness of various therapeutic interventions, the CNS and AANS have developed a joint online practice database.
project through a third party entity, Neuropoint Alliance, that will be designed to collect practical online clinical data for neurological surgery. The expectation is that it will be similar in scope to those maintained by the Society of Thoracic Surgeons and the American Society of Plastic Surgeons and, through the guidance of the ABNS, this important resource will include outcomes, data and studies, benchmarking for individuals or groups, credentialing, device/procedure research, resource utilization and other potential resources.

Numerous other subcommittees and liaisons have been instrumental in advocating for neurosurgeons’ needs to practice effectively and efficiently and deliver optimal patient care. The Coding and Reimbursement Committee continues its excellent work helping to protect the value of our most common (and even less common) procedures. Despite the recently adopted Medicare Bill which staved off a 10.6% cut in physician reimbursement, this legislation is associated with a greater than 20% payment cut (including 20% for 2009) based on the flawed Sustainable Growth Rate (SGR) formula, and also approves further Pay for Performance (P4P) implementation. The WC did not support this legislation and will continue to press hard for meaningful reform of the SGR and Medicare. With respect to the acute care surgery initiative, the WC has developed the Emergency Neurosurgical Task Force being led by Dr. Alex Valadka to ensure the development of recommendations for optimal and efficient emergency neurosurgical care in a multidisciplinary approach. Neurosurgery remains, in accordance with the IOM recommendation, in support of the regionalization of subspecialty, particularly relying on neurological emergency care, effective tort reform, and reasonable neurosurgery emergency care remuneration as the most viable solutions for our ER call coverage issues across the country. Tort reform and evolving EMTALA interpretations also remain extremely important issues where we maintain an active presence and careful vigilance for the sake of our patients and our member neurosurgeons.

SANS Lifelong Learning
SANS Lifelong Learning continues to be a major resource for neurological practitioners and trainees who are preparing for the written or oral board examinations, participating in Maintenance of Certification (MOC), and interested in staying abreast of fast moving changes in our dynamic specialty. The commitment of SANS to cover information important to modern neurological practice, both medical and socioeconomic, has also grown. Ongoing updates of the SANS online modules and extensive peer review of all material in partnership with the ABNS assure the educational quality of the program. These annual introductions of new products and modules have included: SANS Competencies — covering professionalism, communications, regulatory, medicolegal and socioeconomic issues developed in collaboration with the CSNS and SANS: Pediatrics. This coming year, Spinal Neurosurgery and Neurotrauma and Neurocritical Care, will be developed in collaboration with their respective Joint Sections. SANS remains an indispensable resource for the practicing neurosurgeon for MOC and also for the resident in training. The SANS committee remains under the dedicated leadership of Dr. Jason Sheehan and also includes Drs. Michael Steinmetz, Alan Scarrow, and Hugh Garton.

Education Committee
Education is the core mission of the CNS, and the CNS Education Committee remains accordingly our largest and most active standing committee. Under the leadership of Dr. Saleem Abdulrauf, this committee has continued to flourish, consistently producing novel and highly relevant educational programs for neurosurgeons in all practice settings and at all career stages. Their width and breadth continues to grow and expand with the implementation of learning science to the educational products and dissemination through web-based formats. With the launch of the CNS University of Neurosurgery last year, online educational CME accredited courses and opportunities for MOC include the non-clinical
core competencies as well as the gamut of clinical content in differing formats. The CNS University has been organized to improve user interface and facilitate navigation of the site for courses on minimally incisional spinal surgery, management of head and spinal trauma, controversies in epilepsy surgery, endovascular and open management of carotid stenosis, management of brachial plexus lesions, cervical arthrodesis techniques, and other clinically oriented courses. Through the leadership of Dr. Jamie Ullman, there will be further innovations and course offerings with unique opportunities for participatory online interactions in the upcoming year. Lastly, as part of the early career educational training, the CNS continues its annual 3-D Surgical Anatomy Course for Chief Residents under Dr. Abdulrauf. This four-day course hosts upwards of 70 chief/senior residents from U.S. and Canadian programs and serves as a forum for graduating residents to interact with some of the senior educators in the U.S. Using a case-based learning format, 3-D anatomy presentation, surgical approach simulation systems, hands on cadaveric dissection, actual case videos, and operative nuances and complication avoidance, this wonderful educational opportunity has been a great success. The CNS would like to particularly thank Dr. Al Rhoton for his continued dedication to this course and resident training.

Fellowships

Under the leadership of Dr. Elad Levy, the CNS Fellowships program has continued to expand and provide outstanding and unique educational opportunities for young neurosurgeons from North America and abroad. The CNS domestic fellowship awards are for residents, fellows and established neurosurgeons in North America and are meant to help fund research and enhance the education of neurological surgeons at all stages of their careers. With either basic science or translational research or subspecialty clinical fellowships, opportunities abound for enriched training. The CNS Fellowships Program includes expanded training and research opportunities in cranial and spinal neurosurgery, radiosurgery, endovascular neurosurgery, stereotactic and functional neurosurgery, brain tumor research, syringomyelia research, and clinical investigation. Funded either by the CNS Endowment for Fellowships and Education or via corporate sponsorship, these programs are competitive and of the highest quality with explosive growth and quality of candidates applying for these opportunities in the past few years. International fellowships include the CNS/CINN International Fellowships which provide a three to six-month visiting experience for a neurosurgeon outside North America. In addition the CNS Medical Student Summer Fellowships provide summer stipends for medical students to pursue clinical preceptorships, basic/translational research in neurological laboratories, or research into socioeconomic issues pertinent to the field of neurosurgery. We are appreciative of our corporate sponsors who have supported these numerous fellowships through unrestricted educational grants and include: MGI Pharma, Medtronic, Boston Scientific, Micrus and Synthes Spine, in addition to the American Syringomyelia Alliance Project and the CINN Foundation.

Publications

To create a more cost-efficient and productive unit, the CNS developed the CNS Publications and Media Group to integrate all of the organization’s information-based initiatives and to centrally locate our publications within the journal editorial office, the CNS Headquarters and our publisher. This group again exemplifies the CNS’ efforts for new, updated scientific information delivered with state-of-the-art formats in a timely manner. Our journal, NEUROSURGERY, under our editor, Dr. Michael Apuzzo and Mr. Roderick Faccio, remains the premier journal in neurosurgery, distinguishing itself as a highly respected specialty journal and the most highly cited by the scientific community as evidenced by its high and growing impact factor and its role as the preeminent outlet for multimedia neurosurgical information. In addition to its content, the journal continues to set new standards for design, artistic style, inclusiveness of international neurosurgery, and dynamic use of the Internet. While the traditional print journal remains the mainstay, the additional informational opportunities, multimedia formats and cutting edge content have been included as part of the quarterly supplement Operative Neurosurgery, the annual Clinical Neurosurgery, and the Web-based Neurosurgery On-Line as well as the new addition of Podcasts of key articles. Clinical Neurosurgery, under editor Dr. Gerald Grant, was previously just a proceedings of our Annual Meeting and is now a peer reviewed supplement to our journal. The Congress Quarterly (cnsq), completely redesigned by previous editor Dr. Ali Rezai, is an up to date dynamic neurological news magazine with relevant and timely topics on important areas of neurosurgery including MOC, Outcomes, and International Neurosurgery as well as the happenings of the organization. The editorship of the cnsq will be handled in the
upcoming years by Co-Editors, Drs. Jamie Ullman and James Harrop. All of these efforts have been under the direction of the Chair of the CNS Publications Committee, Dr. Robert Friedlander. In addition, we would also like to express our appreciation for our ongoing partnership with our publisher, Wolters Kluwer, and in particular, Carole Pippin and Paul Cook.

**International**

As part of our core mission, the CNS International Committee stands as our direct liaison with our neurosurgical colleagues and members abroad in the development of educational initiatives worldwide. Under the leadership of Drs. Ali Rezaie and Charles Liu, the International Committee has taken on new vibrancy with renewed energy, involving more international societies and developing new partnerships and relationships. It has been a CNS tradition to partner with an international neurosurgical society for our Annual Meeting to discuss new ideas and issues affecting neurosurgeons worldwide. This year for CNS 2008 in Orlando, the CNS partnered with the Brazilian Society of Neurosurgery, a first in South America, and next year in New Orleans we will collaborate for the first time with a society from South Asia, the Neurological Society of India. As well, the CNS has been actively partnering with other societies to develop joint meetings in their home regions. Last year’s joint meeting with the European Association of Neurosurgical Societies (EANS) in Glasgow, Scotland, the recently held joint meeting in Dubrovnik, Croatia with the Croatian Neurosurgical Society, and the upcoming meeting in 2010 with the Neurological Society of India epitomizes the CNS commitment to international neurosurgical education. In addition to our annual and joint meetings, the international outreach this year will include translations of key articles in *Neurosurgery*, as well as translated courses from the CNS University. Key to the success of the CNS interaction with international neurosurgery has been the development of true relationships with international societies to better understand their educational needs and develop individual projects and programs.

**Headquarters**

Since 1999 the CNS has had its own Headquarters Office in Schaumburg, Illinois, with Ms. Laurie Behncke as its first and only Executive Director. Recently the CNS Headquarters Office completed its physical infrastructure expansion to better provide its member services and support all CNS projects and initiatives with a professional staff of sixteen. This highly efficient and motivated staff has concentrated on the direct needs of our members and the organization in membership services and accounting, information technology, member development, meeting planning, and education and scientific program management. The CNS continues to proudly manage the Section on Spine and Peripheral Nerve Annual Meeting scheduled this year March 11 – 14, 2009 in Phoenix, AZ and will be managing the combined Society of Neuro-Oncology and Section on Tumors that will precede CNS 2009 as a satellite meeting in New Orleans, LA.

**Nominating Committee**

Following the recommendations of the CNS Nominating Committee, publication in the Congress Quarterly, and an electronic vote, the following slate of elected officers to the CNS Executive Committee was announced at the CNS Annual Business Meeting in Orlando, FL:

- **President-Elect:** Gerald Rodts, MD  
  (Atlanta, GA)
- **Vice-President:** Joel MacDonald, MD  
  (Salt Lake City, UT)
- **Treasurer:** Daniel K. Resnick  
  (Madison, WI)
- **Member-At-Large:** James Harrop, MD  
  (Philadelphia, PA)
- **Member-At-Large:** Catherine Mazzola, MD  
  (Hackensack, NJ)

In summary, 2008 has been another remarkable year in the life of our organization. The financial situation of the CNS continues to remain strong; through fiscal responsibility, prudent oversight, central office efficiency and productivity and the continued volunteer efforts of our members we have maintained our ability to provide great value for low membership dues. We continue to promote advocacy through our continued support of the AANS/CNS Washington Committee and other important cooperative efforts with the AANS. Further joint efforts to streamline the collection of outcomes data and develop meaningful evidence based practice guidelines are in process and will continue to be the basis of our fight to maintain and improve patient care. Our membership, education and publications efforts as always allow us to support the educational needs of our domestic and international membership and we look forward to further and new partnerships with our international neurosurgical colleagues in the upcoming year. We will continue to build and transform our educational efforts to promote learner-centered experiences with the goal of optimizing the value and relevancy of medical education at our annual meetings and as a continuum during the year. We will also continue to focus on our core mission of education, further utilizing new information technologies to optimize these cooperative educational efforts and develop a dynamic community of learners and educators for the benefit of patients worldwide.
HIGHLIGHTS FROM THE 2008 CNS ANNUAL MEETING, ORLANDO, FLORIDA

A COMMUNITY OF LEARNING

The 58th Annual Meeting of the Congress of Neurological Surgeons was held September 20-25, 2008, in Orlando, Florida. The meeting theme was The Community of Neurosurgery: Wisdom From Shared Experience. The CNS Honored Guest was Dr. William Chandler, Past President of the CNS and Professor of Neurological Surgery at the University of Michigan, Ann Arbor.

The international guest society for the meeting was the Sociedade Brasileira de Neurocirurgia (SBN). SBN President, Dr. Jose Carlos Saleme, and senior member, Dr. Evandro de Oliveira, spoke in the General Scientific Sessions. Numerous Brazilian colleagues appeared in the scientific program and attended the meeting. The CNS Distinguished Service Award was bestowed on Dr. Troy M. Tippett for his career-long contributions to organized neurosurgery and neurosurgical socioeconomics. Dr. David G. Kline was awarded the Founder’s Laurel recognizing his seminal contributions to peripheral nerve surgery and distinguished personal service during the Katrina disaster.

Best Science

2008 was a tremendously successful year, drawing a record number of abstract submissions for the CNS Annual Meeting. The very best contemporary science was presented at the Neurosurgical Forum, which included 83 Open Papers and 212 Select Abstracts. An additional 436 Digital Posters were presented at the meeting. All of these contributions are now archived and available via the CNS web site.

CNS Lectureships

Prof. Maya Angelou – 2008 Dandy Orator. Dr. Angelou, a celebrated American poet, author, actress and civil rights leader, worked in the Southern Christian Leadership Conference for Dr. Martin Luther King, Jr. and read one of her poems at the inauguration of President Bill Clinton in 1993 as she was named Poet Laureate of the United States. Professor Angelou captivated the CNS members with her poetic address on the interconnectedness of humanity.

Dr. Muhammad Yunus, PhD – Michael L.J. Apuzzo Lecturer on Creativity and Innovation. Dr. Yunus won the 2006 Nobel Prize in Economics for his development of the microcredit anti-poverty movement and his role as founder of the micro-credit Grameen Bank in Bangladesh. Dr. Yunus energized the CNS audience with his call to individual and collective action on behalf of the powerless in societies across the world.

Dr. Atul Gawande – 2008 Special Lecturer. Dr. Gawande is a general surgeon at the Brigham and Women’s Hospital interested in surgical training, ethics, culture and safety, as
well as a celebrated columnist for the New Yorker and author of two New York Times Best Selling Books: Complications and Better. Dr. Gawande enthralled our audience with his eloquent tales of life lived as a surgeon.

James Surowiecki – 2008 Special Lecturer. An economist, Mr. Surowiecki is the foremost authority on how to harness the collective wisdom of organizations for competitive advantage. He is a columnist for the New Yorker and author of the best selling book The Wisdom of Crowds. Mr. Surowiecki caught the attention of the CNS members with his compelling description of the wisdom of collective decision making.

Ed Viesturs – 2008 Julian T. Hoff Memorial Lecturer. Mr. Viesturs is the first American and only one of a handful of individuals ever to scale all fourteen 8,000 meter peaks in the world, and he did it without supplemental oxygen. Mr. Viesturs impressed the Orlando audience with his captivating stories of teamwork and safety in mountaineering.


Scientific Program Highlights
The General Scientific Sessions explored sources of knowledge for the Community of Neurosurgery. The Monday session investigated translational science; Tuesday’s session, medical evidence; and Wednesday’s, collective wisdom. The Thursday General Session concentrated on case based learning, with Digital Masters surgical presentations and Cases and Coffee with the Masters, using section-based break out rooms to consider cases submitted by meeting attendees.

Additionally, the CNS provided free continuous wireless access to all attendees within the convention center venue in Orlando. As well as providing e-mail and information connectivity to attendees, wireless access supported the most interactive educational meeting in the CNS history. This interactive technology was used in the General Sessions to facilitate live upload of digital questions to the main stage. Subspecialty-based Integrated Medical Learning® (IML) sessions also utilized digital interactivity to assess current opinions, knowledge and practice in seven key areas of practice. Data from these sessions will be analyzed and shared with all members of the Community of Neurosurgery in feedback presentations and publications.

In addition, five interactive Consensus Sessions on Monday, Tuesday and Wednesday explored timely and controversial areas of policy affecting neurosurgical practice, and helped to generate, quantify and analyze informed opinions that can point towards potential solutions and regulatory interventions. The topics covered included managing conflict of interest, redesigning residency, emergency neurosurgical coverage, re-certification after disability and negotiating with insurance companies.

The 2008 Annual Meeting also presented a wide array of Practical Courses. Many of these
offerings were designed to impart specific analytical or practical skills to participants that they can use in grantsmanship, evidence based practice and knowledge generation. The Neurosurgical Forum also offered “toolkit” presentations on developing clinical and basic science grants and projects, plus an interactive poster session introducing active multi-center clinical trials. A further toolkit session focusing on effective professional and academic communications was taught by expert faculty from the Nicholson School of Communication at the University of Central Florida.

A wide variety of surgical and technical skill sessions remained a mainstay of the Practical Courses, including opportunities for both beginners and experts to work on sophisticated endovascular simulators. Similarly, the CNS Luncheon Seminars program offered a host of new courses and updated faculty and offerings within existing courses. Finally, the Orlando meeting hosted a return of the extremely popular, case based learning event, 3D Cadaveric Surgical Dissections with the Masters.

Science of Continuing Medical Education
The 2008 CNS Annual Meeting emphasized three new efforts to improve continuing medical education by utilizing modern educational science:

Meeting as Workshop – The meeting incorporated a number of scientific activities that involve the combined participation of learners and experts to evaluate existing scientific and clinical evidence, assess knowledge attitudes and practice, and generate specific new data relevant to neurosurgical education.

Toolkits for Knowledge Building – The meeting also incorporated numerous activities designed to give participants specific didactic tools for analysis and knowledge building (such as statistical and trial design methodology) and then application of these tools to specific case examples (for example, important recently published clinical trials).

Learner-Centered Participation – Adult learning theory dictates the importance of active participation to retention and later application of new knowledge. The 2008 Scientific Program emphasized interactive software, learner surveys, polling and literature review as part of both IML and Consensus sessions.

All of these activities are part of an overarching strategic goal of the CNS to be a leader in the science of Continuing Medical Education. As part of these efforts, the CNS is capturing, analyzing and sharing information about the results and effectiveness of our novel educational programs with our membership and with the broader neurosurgical and educational communities.

The 2008 CNS Annual Meeting was carefully designed to allow attendees not only to learn more about the most current trends in neurological surgery, but also to advance our specialty by acting as active participants in a workshop of ideas. The benefits of participation will continue to accrue in coming months as outcomes from those interactive sessions are analyzed and published. Join us to continue our work together in October 2009, at the CNS Annual Meeting in New Orleans!
M
eet the “new” CSNS: better armed to
address the growing socioeconomic
issues facing neurosurgeons every-
where. Neurosurgeons are faced with diminish-
ing reimbursements, rising costs, a plethora of
unfunded federal and state mandates, threats
from medical tourism and dramatic changes in
resident and post-residency education, to
name just a few of our current challenges.

Since 1963, the CSNS or its predecessors
have given a voice to every neurosurgeon on
these issues. Increasingly over time, the CSNS
has also become a critical resource for educa-
tion, advocacy, leadership and innovation.

While the CSNS remains the sole repre-
sentational, deliberative organization for national
neurosurgery, it has also evolved into a signifi-
cant product-oriented association, no long er
just responding to crisis situations.

Over the last few years, the CSNS has
undergone dramatic growth, established
many new programs and products, and
launched many of the current AANS and the
CNS officers. Thirteen Presidents of the AANS
and the CNS achieved those leadership posi-
tions in considerable part because of their
endeavors in the socioeconomic activities of
their organizations and one CNS President
and three AANS Presidents served as CSNS
Chairman prior to leading the national organi-
zation. Jim Bean, current AANS President and
former CSNS Chairman has noted, “You can’t
effect change by staying home and hunkering
down in the OR. We all need to play some role
in the wider aspect of neurosurgical practice
starting with attending your state neurosurgi-
cal society meetings and moving on to the
CSNS as a delegate, a contributing committee
member and hopefully a committee chair or
as an officer. I followed that path and have
been richly educated and rewarded for spend-
ing my time.” It seems appropriate to highlight
some of these developments during our 45th
anniversary year.

In 2006, the CSNS initiated a Strategic
Planning process. The CSNS had remained
largely unchanged since a restructuring spear-
headed by Stan Pelofsky and Jim Bean in

> YOU CAN’T
EFFECT CHANGE
BY STAYING HOME
AND HUNKERING
DOWN IN THE OR. <
1995 which introduced the current resolution process. During the subsequent decade, numerous resolutions were introduced by delegates from states, caucuses and committees. Those involved in the strategic planning, however, felt that we still remained a largely reactive group with little productivity except during our two annual meetings. With the support of our two parent organizations, AANS and the CNS, much growth has been realized. David Adelson, current President of the CNS, recently commented, “The Congress values the input we receive from the CSNS. It keeps us abreast of what is of concern to the neurosurgeons throughout America and is an ongoing, unique source for socioeconomic information and education for the members of the Congress.”

The basic structure of the CSNS remains unchanged. Each state is entitled to send one neurosurgeon representative. There are also representatives appointed to the CNS and AANS caucus and 13 resident delegates. The Council meets twice a year just before the annual meetings of the AANS and the CNS, when it considers resolutions submitted by delegates or its committees and receives reports from those committees as well as the AANS and the CNS. Resolutions that are adopted by assembly vote are sent to the AANS/CNS for consideration and potential implementation.

The committee structure is the critical backbone of CSNS work. Dynamic committee chairs and active year-round participation by committee members have resulted in numerous superb products. For example, the Communication and Education Committee (CEC) has dramatically impacted the level of socioeconomic education available during both the CNS and AANS meetings. For years, the only education available in this realm was courses in coding and reimbursement. Slowly over the years, the CEC has developed courses in a wide spectrum of socioeconomic issues (such as negotiating with insurance companies, alternative practice environments, etc.) and once interest was obvious, both the AANS and the CNS have established additional courses on their own. To systematize this education, the CEC created a complete socioeconomic curriculum and is slowly adding course content or resources to every topic of the outline (http://csnsonline.org/education.php).

The Workforce committee has become one of the most active committees under the vibrant leadership of Ann Stroink, MD (Illinois delegate). For example, they have taken on a fascinating project to understand the potential impact of medical tourism and globalism on the American neurosurgical workforce. During this same time the Neurotrauma and Emergency Neurosurgery group has written a core competency curriculum and a web-based tool for Regionalized Trauma Self Assessment. The web site contains many resources, such as tools for negotiating with hospitals, RVU basics and trial preparation. There is also a speaker’s bureau on the entire spectrum of socioeconomic issues.

The CSNS is also a welcoming organization for involvement by the entire diverse spectrum of neurosurgeons. In response to a younger workforce that is becoming more diverse in representation and cultural acuity, the CSNS has welcomed state delegates and AANS and the CNS appointees whose rich background lends new perspective in identifying the socioeconomic concerns affecting neurosurgeons across the country. The CSNS recognizes there is strength in diversity as exemplified by the increased presence of minorities and women in leadership roles. For example, Dr. Ann Stroink joined the CSNS in 2005 and now chairs the Workforce Committee. “Acquiescing to Illinois neurosurgeons’ requests to become a delegate and having established a solid practice with several partners, I elected to fully participate in CSNS activities, including leading the Workforce Committee. It is an opportunity to give back to organized neurosurgery,” she says. Since 2001, two women have served as CSNS secretary and presently three of the CSNS standing committees are chaired by women.

Young neurosurgeons have also been actively courted as delegates. In the Fall of 1999, the first 12 residents were invited by the CSNS Executive Committee (pending development of a formal quadrant selection process) from among applications submitted by the training programs to the various quadrant chairpersons. Full funding for the residents’ travel and lodging was provided by a grant which had been solicited by Dr. Leibrock, then CSNS Chairman. In the Spring of 2001, the CSNS voted to give the resident delegates full voting privileges. In 2008, the CSNS Socioeconomic Fellowship program was initiated, with the fellows selected through a competitive application process. In its first year, there were over 30 outstanding applicants for just 13 positions. As designed, the Fellowship will provide a comprehensive socioeconomic introduction beyond just attending two sequential meet-
ings as delegates. These Fellows can then serve as a local socioeconomic resource to their programs and immediate communities and hopefully continue their involvement in the critical work of the CSNS. (For more information and application, see https://csnsonline.org/fellowships_awards.php)

Working jointly with the Washington Committee, the CSNS has undertaken the ambitious project of establishing a complete network of state political chairs. These individuals would serve as connectors between each state’s neurosurgeons and the national political action groups. In this way, critical advocacy issues could flow in both directions. Recently, there was a crisis in Washington concerning workers compensation. By activating this rapid response system, crucial information was gathered that allowed the neurosurgeons in Washington to successfully battle a crushing proposed change. It is expected that similar rapid response efforts could benefit many neurosurgeons on both local and national issues of advocacy.

Throughout its years of existence, the grassroots concept embodied at first by the National Advisory Group (http://csnsonline.org/history.php) and subsequently by the Council of State Neurosurgical Societies has functioned well to promote egalitarian input into the generally hierarchical leadership of the AANS and the CNS. The CSNS will only ever be as strong as its membership and effective in how well it meets the needs of every neurosurgeon. We encourage you to join, to participate, to get involved. Those who have feel enormously rewarded. We want to hear your voice, your concerns and your successes.

> THE CSNS WILL ONLY EVER BE AS STRONG AS ITS MEMBERSHIP AND EFFECTIVE IN HOW WELL IT MEETS THE NEEDS OF EVERY NEUROSURGEON. <

>CSNS OFFICERS

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In the U.S. each year, over one million patients are seen in emergency rooms for traumatic brain injury alone, representing only a portion of the emergency cases that neurosurgeons are asked to see on a daily basis. The high volume of emergency neurosurgical cases currently tests the ability of neurosurgeons to meet this demand, but varies widely from region to region throughout the United States.

Neurotrauma issues affecting neurosurgeons today include, but are not limited to:

(1) Do all neurosurgeons have an obligation, as most have felt in the past, to provide care for patients in their own emergency room(s) for little or no extra reimbursement? Should the number of other surgeons in the area or the likelihood of patient insurance coverage influence these decisions? Are contractual agreements for emergency coverage viable in any given area of the country and how might they be negotiated as a “win-win” arrangement for physician and hospital?

(2) Conversely, are we providing all neurosurgery residents with sufficient training to offer comprehensive emergency care for patients we see on call? Have current 80 hour resident work week restrictions, not to mention possible additional restrictions (from 80 to 56 hour work weeks), affected the quality of residents’ emergency care as they begin their careers after training?

(3) Should general surgeons be more involved in the management of neurological patients? Do they have a primary role in the care of neurotrauma, emergency neurosurgery, or neither? Does this differ in areas where there are no neurosurgeons or where neurosurgeons have refused to cover ERs or have not renewed their cranial privileges?

(4) What are the most viable options for continuing to provide the highest level of care to neurological patients with the manpower, medical liability and reimbursement issues we face in this country? What will be the roles of changes in neurological training, changes in general surgical training (“acute care surgery”), midlevel providers of neurological care, and regionalization of trauma care; more importantly, how will the neurological community ensure a place at the table in deciding the answers to these issues?

These are just a few of the issues addressed by the Neurotrauma and Emergency Neurosurgery Committee, along with many others that regularly arise, from the local to the national level.

In 2007, Dr. Shelly Timmons assumed the position of Chair of the Neurotrauma and Emergency Neurosurgery Committee. Her committee is responsible for reviewing all resolutions which bear on emergency neurosurgery, as well as for responding to requests by the CSNS (in the form of passed resolutions from the plenary sessions, or directly from the Executive Committee) to research pressing issues and return with status reports or possible solutions to these issues. These may include subjects where there is great disagreement within the neurological community or between academic and community perspectives, making for a very lively but comprehensive discussion on the many aspects of a problem and its many possible solutions. Dr. J. Adair Prall serves as Vice Chair, and maintains a very active role within the committee.
Below, Dr. Timmons participates in an in-depth discussion with the CSNS editorial/publication committee.

How long have you chaired this committee and who was your predecessor? How many members are on this committee and what kind of members are you looking for? Do you have to be a member of the CSNS to work on this committee?

Dr. Timmons: I assumed the chair of the Committee on Neurotrauma in July 2007. Domenic Esposito preceded me as chair. We recently changed the name of our committee to the Neurotrauma and Emergency Neurosurgery Committee to more accurately reflect our activities and to ensure the ongoing relevance of the committee within the CSNS, and within the greater neurosurgical community. Although neurotrauma issues appear in the spotlight on a regular basis, these same issues have an impact on all emergency neurosurgical care, from cauda equine syndromes, to subarachnoid hemorrhage, to subdural hematomas.

We have about 15 members currently, all of whom are CSNS members, and anyone attending the CSNS meeting is welcome to attend our committee meetings. We have enjoyed resident participation in the past, and encourage more in the future. CSNS membership is not required to sit in on committee work sessions, and in fact, those with special interest in or knowledge of issues to be discussed at a given meeting or to be addressed in a given work project are strongly encouraged to participate. Our committee is comprised generally of academic, community and military neurosurgeons who want to influence the future of emergency neurosurgical care delivery.

Does this committee get involved in the review of levels of evidence for trauma that eventually form guidelines for neurotrauma management? Do the guidelines address any socioeconomic issues?

Dr. Timmons: The committee has reviewed EBM guidelines in the past. Although the Joint Guidelines Committee has been tasked with the final review of all practice guidelines efforts for the AANS and the CNS, most neurotrauma practice guidelines contain some content regarding delivery of care (organization of trauma systems, e.g.) and thus relate to the issues addressed in this committee. Many of our members have multiple roles outside the CSNS; for example, I sit on the Executive Committee of the Joint Section for Neurotrauma and Critical Care, and our co-chair, Dr. Adair Prall, also sits on the Joint Guidelines Committee, so we have input both to and from a number of other committees reviewing guidelines efforts relating to emergency neurosurgery. This interconnection among different arms of organized neurosurgery is designed to strengthen and streamline all of our efforts. Our committee welcomes the opportunity to review/participate in future guidelines production related to neurotrauma.

Are you involved in the Brain Death Protocol and do you work in conjunction with other committees on this issue?

Dr. Timmons: The committee did participate in the review of the Brain Death Protocol along with the Young Neurosurgeons Committee. We are participating with that committee in an ongoing basis with the development of evidence-based guidelines for determination of brain death. We have also worked with the Education Committee to provide content for the SANS neurosurgical review.

What projects are you currently working on? What involvement do you have with the idea of regionalization of trauma? Any anticipated socioeconomic impact? Any plans for a “white paper” on trauma issues in the near future?

Dr. Timmons: We are currently working on two major projects. We recently completed a core curriculum for emergency neurosurgery, outlining those aspects of neurosurgery with which every practicing neurosurgeon ought to be competent as they leave their training program. This was assigned in response to a resolution from the CSNS plenary session and is important in providing guidance for the neurological community and the broader medical community in establishing necessary skills for the care of emergency neurosurgery patients to ensure that patients receive prompt care. The curriculum has been posted on the CSNS web site; a related ongoing project is the development of a “white paper” on the same subject.

Our other main project is an interactive electronic workbook for self-assessment and organization of regional neurotrauma and emergency neurosurgical care. We will be
working with the Communications Committee on this project. The idea is to provide a clearinghouse of information for various geographical regions: data will include hospital locations and levels of care, hospital and physician resources, patterns of transport, etc. as well as other resources for assisting in regionalizing care (call-sharing models, sample transfer agreements, etc.) We expect this project to provide tremendous benefit to areas of the country where resources for emergency care are less well developed. Hopefully, those in areas where this type of assessment and organization is further developed will fortify this interactive tool with data from their own experience, thereby efficiently transferring their “lessons learned” across the country to others following them in this endeavor.

Recently, the Institute of Medicine has suggested that work hours for residents in training be dropped from 80 to 56 hours; however, many articles suggest (and confirm) that work hour reductions would negatively impact neurosurgical training and may result in compromising patient safety due to the resulting discontinuity of care. Have you addressed this issue in your committee?

Dr. Timmons: The committee has discussed the move to curtail resident work hours even further and is very concerned about the possibility of any further reductions. Among resident, community and academic committee members alike, there is a consensus that with any further limitation of resident hours, training programs will have great difficulty adequately training their residents in emergency procedures and operations; there is also concern over patient safety related to the increased number of required “hand-offs,” challenging the historically high levels of care continuity in neurosurgical residency training programs.

There may be a movement to modify the training of neurosurgeons to a fast-track, establishing basic skills for neurotrauma, cranial and spine work, and allow neurosurgeons to pursue “advanced clinical training” or further areas of interest in fellowship programs. Any comments?

Dr. Timmons: At this time, there is no formal committee stance on the subject of modifying neurosurgical training, but the obvious concern would be that the workforce available to provide emergency care to neurosurgical patients (which is already shrinking) would be further diminished, negatively affecting patient care and outcomes.

Neurosurgeons in some areas are opting out of emergency care, or in some cases, maintaining privileges in spine but not cranial surgery? Is this unusual and how concerning is this?

Dr. Timmons: This phenomenon has been noted in a variety of regions throughout the country. Our committee is supportive of efforts to make caring for neurotrauma patients less onerous and regionalizing care so that patients can receive the best care possible in the most timely fashion. Models including reimbursement for emergency coverage, call sharing with multiple groups or provision by hospitals for locum tenens call coverage are being explored throughout the country. One of the most interesting parts of our committee experience is hearing about ideas that are being tested in various parts of the country; our committee is one mode of idea transfer for some of these new models.

How can a neurosurgeon join your committee and what type of responsibilities would a working member expect to have?

Dr. Timmons: A neurosurgeon can join the committee by either attending a committee meeting or contacting me by e-mail (stimmons@utmem.edu). Responsibilities include meeting attendance and working on specific projects as they are assigned by the reference committee, typically involving researching a topic and collaborating on written efforts, or providing content for educational projects. Those with web development skills are welcome to provide technical contributions for web-based projects, streamlining communication within the committee between meetings, or to improve the committee web page as well.
Membership in CSNS among younger neurosurgeons has significantly increased over the last 10 years. Membership has been enhanced not only by the CSNS-sponsored programs designed to promote resident physician involvement, but also by the CSNS’ demonstrated commitment to address issues concerning all members of the neurosurgical workforce.

Due to this growing number of younger members, it became apparent that a Young Physicians Committee (YPC) would best give the CSNS a persuasive new voice in professional development and a new direction to explore various socioeconomic topics. The YPC meets twice a year during the CSNS meetings to author and review resolutions.

Equally important, the YPC is seen as a springboard for residents and neurosurgeons recently joining practice and/or academic positions to establish themselves as the future leaders of organized neurosurgery. Past members and chairs of this committee have contributed to a body of thought-provoking ideas and projects that concern socioeconomic issues, fostering a milieu for academic achievement and practice management satisfaction. Program directors recognize the positive impact of well-versed neurosurgical trainees and graduates and are supportive of resident involvement as the foundation for a future, well-informed neurosurgical workforce.

Catherine Mazzola, MD, is the energetic chairperson of the Young Physicians Committee. Through her enthusiastic encouragement, there has been an influx of new committee members fortifying and developing work previously started by other chairpersons such as Drs. Satish Krishamurthy, Joshua Rosenow and Edie Zusman. Recent undertakings such as the Brain Death Guidelines Project and Neurosurgery Residency Evaluations are some of the important and stimulating projects that the YPC is currently orchestrating. Dr. Mazzola encourages further participation as a means of advocacy for young neurosurgeons, not only for themselves but also for their contemporaries. Rapid communication via e-mail and e-blasts in between the traditional biannual meetings allows members to freely exchange ideas to further develop projects.

THE YPC IS SEEN AS A SPRINGBOARD FOR RESIDENTS AND NEUROSURGEONS RECENTLY JOINING PRACTICE AND/OR ACADEMIC POSITIONS TO ESTABLISH THEMSELVES AS THE FUTURE LEADERS OF ORGANIZED NEUROSURGERY.
Could you give the readers a history of when the Young Physicians Committee was started and why it was formed? Is it intended to assist young neurosurgeons? Do you have a mission statement?

**Dr. Mazzola:** The Young Physicians Committee was developed several years ago as a standing committee of the Council of State Neurosurgical Societies. The purpose or mission of the YPC is to educate, interest and involve young and resident neurosurgeons in current CSNS and AANS/CNS organizational activities related to socioeconomic issues of neurosurgery practice. We undertake research and report on educational projects or issues of particular interest to young neurosurgeons, including job search, practice initiation, Board certification and recertification, training conditions, practice economics and other related topics.

What is the purpose of the Young Physicians Committee and how does it fit into the organization as a whole?

**Dr. Mazzola:** YPC meets regularly at the CSNS meetings, which occur just before the annual meetings of the AANS and the CNS. Resolutions that have been submitted by YPC for discussion and presentation at the CSNS caucus meeting are discussed. Other resolutions submitted by state neurosurgery societies, independent neurosurgeons or other committees may also be assigned to YPC for discussion and debate. Since our primary interest focuses on the career development of the young neurosurgeon, residency issues, board certification issues and practice development are key topics of interest to YPC.

What projects have you worked on in the past? Do you find that younger neurosurgeons are more apt to be interested in the socioeconomic aspects of neurosurgery?

**Dr. Mazzola:** YPC has contributed to the development of “Gray Matter” on the CNS web site and other educational programs. Drs. Satish Krishnamurthy, Joshua Rosenow, Edie Zusman, Mick Perez-Cruet and other past chairs of YPC have been instrumental in the development and support of many resident educational programs, including the Medtronic-sponsored resident fellowships of the CSNS. Additionally, over the past year, YPC submitted a resolution proposing a post-residency graduate survey. We created a model of an online survey that could be mailed to residency graduates after board certification. We would like to obtain data about the adequacy of neurosurgical residency training. Our resolution was accepted and the model survey has been submitted to the Executive Committee of the CSNS. The model has also been presented at the Educational Summit in Washington, D.C.

What projects are you currently working on and who decides what projects you and your committee should tackle?

**Dr. Mazzola:** The YPC is currently working on the Neurosurgery Residency evaluations. Once we receive recommendations from the Educational Summit Committee and the Education Committee of the CSNS, we will incorporate the suggested modifications into the current model. We would like to e-mail the survey in May or June of 2008.

Our project ideas come from our members, the resolutions written by the YPC members, suggestions from the Education Committee, and sometimes by request from other committees. Together as a group, we discuss the proposed projects and define task force teams. Within the team, guidelines are set and project assignments are created.

Please tell us, in some detail, of the Brain Death project that you have recently completed. Has your committee provided for any continuing medical education in regards to this project or any others?

**Dr. Mazzola:** The brain death protocol was submitted as a resolution at the spring 2007 CSNS meeting. The resolution was written by me with support from my partners in New Jersey, as well as from the N.J. Sharing Network, an organ procurement organization. The resolution proposed that brain death pronouncement guidelines for neurosurgeons should be created by an appointed task force. With recent advances in neuroimaging, the reliability of CT and MR angiogram should be investigated in...
relationship to the assessment of cerebral blood flow. Some states allow CT or MR angiogram as a “confirmatory” test. There is also significant confusion regarding the presence of barbiturates in the blood and the impact this has on cerebral blood flow and the pronouncement of brain death. While the goal of this project is to provide education and information for neurosurgeons regarding the pronouncement of brain death, there are no specific CME credits associated with the project at this time.

This interview is an opportunity for you to promote your committee’s work; what would you like to say to the readers to encourage them to consider working on and with this committee?

Dr. Mazzola: The Young Physicians Committee is a very active standing committee of the CSNS. There are many young neurosurgeons who join YPC as their first committee within CSNS. The YPC provides the means and opportunity for young neurosurgeons to become advocates for themselves and their contemporaries. YPC gives a voice to the young neurosurgery graduate. YPC is striving to create an environment of change that would be welcomed and supported by the Senior Neurosurgical Society, as well as by our other parent organizations. We receive guidance from the Education Committee and do the work needed to take our projects and ideas to completion.

Besides publications, it appears the CSNS has ample opportunity to allow for the presentation of papers at the CNS and AANS meetings. How does your committee promote such activities?

Dr. Mazzola: Our committee allows an open forum for young residents and graduate neurosurgeons to express their concerns and ideas. These issues are discussed and debated by the group at our meetings and online. Occasionally, we submit resolutions and generate projects that address our concerns.

Have you or your committee generated any questions that could be utilized by the SANS course sponsored by the CNS? Do you have any plans for future questions?

Dr. Mazzola: YPC members have contributed in the past to SANS questions. The CSNS has been very active in the creation and compilation of questions, especially in the area of socioeconomic and medicolegal aspects of neurosurgery.

Please tell the readers when your committee meets next and how to contact you ahead of time to answer any questions.

Dr. Mazzola: The YPC communicates among members via e-mail and e-blasts in between meetings. We meet regularly at the CSNS meetings which occur the two days prior to the CNS and AANS annual meetings. Anyone may join the YPC through the CSNS. Young neurosurgeons may contact me by email at camazzola@atlanticneurosurgical.com or ruebenacker@hotmail.com. Their ideas, suggestions and concerns are welcome. Additionally, young neurosurgeons may contact their state representatives or the CNS or AANS representatives in order to convey their comments. The CSNS website, www.csnsonline.org, is another excellent way to get more information about YPC.
The CSNS functions throughout the year via working committees that address the socioeconomic concerns pertinent to neurosurgery. In this regard, the CSNS is charged with providing educational materials through CME offerings at national meetings and throughout the year, as well as in publications. In order to carry out this duty, the Communication and Education Committee (CEC) meets regularly, led by dedicated chair Dr. Michael Steinmetz.

The CEC is responsible for the development and delivery of socioeconomic educational programs at the national CNS and AANS meetings, including breakfast and luncheon seminars, practical courses, and specially focused skills courses. The planning process for the CEC includes selecting topics based on the reported needs of neurosurgeons and also identifying appropriate faculty members to address socioeconomic learning objectives. Abstracts related to pertinent socioeconomic neurosurgical issues are reviewed and selected by members of the CEC for presentation at the annual meetings of the CNS and AANS. Concomitantly, the CSNS runs a socioeconomic session at national meetings on selected socioeconomic abstracts, allowing for both education and feedback through the interaction between the audience and educator, promoting well thought out publications.

Additionally, the CEC is charged with developing skill-based learning activities that are offered to neurosurgeons and staff members including negotiations, time and risk management, and medico-legal development. These practical courses have generated great interest and have promulgated widely popular course topics such as coding and reimbursement challenges in neurosurgery, practice management workshops and the neurosurgeon as CEO. The number of offerings has increased over the last decade; for example, there were 19 socioeconomic courses at the AANS spring session, attesting to the mounting interest in relevant socioeconomic topics. Moreover, these courses address core competencies related to professionalism and systems-based practice, which generates material for SANS (Self Assessment in Neurological Surgery) Lifelong Learning and Maintenance of Certification (MOC) examinations.

The CEC is looking for interested members who attend the CSNS meeting and are willing to promote education through socioeconomic avenues, provide time and talent in reviewing and selecting abstract submissions for future educational sessions, and also promote the creation of publications and informative web site offerings.

What is the Communications and Education Committee? What is its purpose?

Dr. Steinmetz: The CEC is the communications and education arm of the CSNS. The main function of the committee is to develop and coordinate socioeconomic educational material to be delivered electronically via the web site at the annual CNS and AANS meetings and also in...
How does the CEC function as part of the CSNS? Does it have subcommittees?

Dr. Steinmetz: The CEC is a standing committee of the CSNS with multiple subcommittees. These subcommittees include website, mentoring, fellowship and publications.

How often does your committee meet? Do you correspond throughout the year? Is this done primarily by e-mail or conference calls?

Dr. Steinmetz: The CEC meets four times per year. Throughout the year, the committee continues communication through e-mail or conference calls as needed.

What does your committee have to do with determining continuing educational programs on socioeconomic topics? Do you use feedback from participant evaluations in determining content?

Dr. Steinmetz: The CEC is responsible for developing and delivering socioeconomic educational offerings. These include practical courses, breakfast and luncheon seminars, and special courses. There is a CSNS session at both the AANS and CNS meetings. During these sessions, abstracts are presented on socioeconomic topics. The CEC develops topics and presentations for these sessions as well. The committee utilizes feedback from members to develop these offerings as well as a socioeconomic core curriculum located on the CSNS website, www.csnsonline.org.

Does your committee review socioeconomic abstracts that are submitted to the AANS and CNS meetings? What is the process utilized in doing so?

Dr. Steinmetz: The CEC is charged with the review of socioeconomic abstracts presented at the annual meetings. The chair of the CEC organizes a review committee, consisting of at least three members of the CEC as well as the Chair.

What types of socioeconomic issues tend to be most popular among neurosurgeons? How involved is your committee in determining practical courses at national meetings and/or web-based educational products?

Dr. Steinmetz: The most popular socioeconomic issues tend to vary year to year, largely depending on any issues at hand. Common and popular topics include CPT coding and reimbursement, practice efficiency, contract negotiation and medical liability.

How does your committee encourage and/or promote the study of socioeconomic topics pertinent to the neurosurgeon?

Dr. Steinmetz: The CEC is actively involved in socioeconomic education. Our mission is to present topics that are relevant and timely to the practicing neurosurgeon. We also maintain a curriculum of core socioeconomic topics and present these on an ongoing basis.

Certain socioeconomic courses seem to provide skill-based learning activities, for example, effective negotiations, time management and risk management. Do you get feedback on how effective these courses are in developing socioeconomic skill sets for neurosurgeons?

Dr. Steinmetz: This is something organized neurosurgery has not tracked well. The current evaluation process of course material is fairly superficial and rarely done in a true and effective manner. These evaluations would have to evolve and would have to be done at some predetermined time following the course to evaluate its effectiveness. The CSNS through the Young Physicians Committee, with some help from the CEC, has taken the first step in this process by surveying those who have recently taken their board exams on these and other skill sets and knowledge.

Please tell readers what forums are available to neurosurgeons who are interested in learning more about socioeconomic issues, i.e., journals, educational sessions, web-based products, books, SANS or MOC?

Dr. Steinmetz: There are many socioeconomic offerings. First and foremost are the educational courses offered at the annual meetings. For example, at the AANS 2008 meeting there were 19 courses/sessions offered. The Congress Quarterly and AANS Neurosurgeon both publish articles on socioeconomic issues and the CSNS publications subcommittee encourages and writes articles for these periodicals. SANS offers web-based CME courses on socioeconomic topics as well.

How does the CEC reconcile the concerns raised by the Senate Finance Committee on the influence of industry on physician education? Will these impact socioeconomic educational activities?

Dr. Steinmetz: Up to now, the CEC has not relied on industry to support our educational offerings. In a large part our annual meetings rely on industry support to finance their efforts. It is critical that all of these courses/sessions be free of commercial influence and bias. The CEC has no direct support from industry. All of its members follow a strict conflict of interest disclosure.
Congress of Neurological Surgeons
2009 ANNUAL MEETING
New Orleans, Louisiana
October 24-29, 2009

Join us in New Orleans, Louisiana for the 2009 CNS Annual Meeting, as we explore our theme A Culture of Excellence.

Look for ground-breaking original science and unique educational sessions including:

- **3-D Live Cadaveric Demonstrations**
  Neurosurgical Masters demonstrate surgical techniques using state-of-the-art, 3-Dimensional imaging technology and cutting-edge videos.

- **Top Ten Abstracts Session**
  Presenting the ten best abstracts from each neurosurgical subspecialty in a concentrated, interactive symposium. Authors deliver eight-minute platform presentations, followed by two-minutes of expert and audience discussion.

- **CNS Neurosurgical Forum**
  This multi-disciplinary session allows Neurosurgical Forum authors to present their abstracts dynamically to small groups, using illustrated posters and computer based media.

- **Consensus Sessions**
  Contribute to the advancement of organized neurosurgery by weighing in on critical socioeconomic issues and public policy topics.

Registration opens Early 2009 at www.cns.org!

Call for Abstracts
Submit your abstract online at www.cns.org.
Deadline: April 10, 2009!

For More Information
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www.cns.org
Toll Free: 877 517 1CNS
Phone: 847 240 2500
T
he First Joint Symposium between the National Neurotrauma Society (NNS) and the AANS/ CNS Section on Neurotrauma and Critical Care took place this past summer at the Hilton Walt Disney World in Orlando, Florida, July 26-30, 2008 and was felt to be a resounding success. There were over 600 registrants, which marked the largest domestic neurotrauma meeting ever with over 275 clinicians participating. The Annual National Neurotrauma Symposium (of which this was the 26th) is the premier annual meeting of the neurotrauma community and provides opportunities for basic scientists, clinicians and allied health workers to meet and discuss timely topics and questions related to pathophysiology, recovery mechanisms, and treatment of spinal cord (SCI) and traumatic brain injury (TBI).

The NNS has traditionally been more concerned with laboratory science. Through this joint effort with the Section, the scientific program committee created a program that was expanded to include specific clinical sessions for the practicing physician as well as the basic scientist to better understand the state-of-the-art management of neurotrauma and critical care. This meeting provided an exciting and unique opportunity for clinicians and basic scientists to convene through lectures (Management of TBI, spinal cord injury and intensive care), hands-on workshops (Spinal column trauma reconstruction, multimodality monitoring and surgical management for brain trauma), and spectacular poster sessions. Over 350 posters were presented during four rotating sessions covering basic laboratory science, translational, and clinical science on TBI, spine and spinal cord injury, and intensive care. Participants were eligible to receive over 23 hours of trauma-specific AMA PRA Category I CME credits.

Most of the clinical sessions were standing room only due to the unexpectedly large turnout for this meeting as well as the extremely welcoming interest of the basic science community. The attendance, the scientific sessions, and the social interaction and activities exceeded expectation. All who attended came away with an understanding of the present state of neurotrauma management, practical tools to apply in the clinical setting, new ideas and thoughts for future investigation, and a wonderful appreciation of what to expect (hopefully soon) in the future.

Because of the success of this first joint symposium, the Section will again be partnering with the NNS along with the International Neurotrauma Society (INTS) for the Second Joint Symposium to take place September 7-11, 2009 in Santa Barbara, California. Visit the web site for updates: http://www.neurotrauma.org/2009/index.htm. We hope to see you there!
From a financial standpoint, Fiscal Year 2008 was a success for the Congress of Neurological Surgeons. In spite of tumultuous economic times in the global economy, the conservative investment strategy of the organization and a frugal posture of the Executive Committee with respect to expenditures has afforded the organization ongoing stability and financial security. The Congress continues to operate as a non-profit 501(c)(3) organization under the Federal Tax Code. The revenue sources for the organization remain unchanged this year and are comprised of publications, member dues, Annual Meeting revenue and other educational products.

**Finances**
During Fiscal Year 2008, the organization performed well against budget. The budgeted income for 2008 was $9,530,524 and the budget expense was $10,142,047 for a net loss of $611,523. Cost saving measures combined with better than expected income from the Annual Meeting resulted in an actual income of $8,914,149 and actual expense of

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**Table 1 > Assets (As of 6/30/2008)**

<table>
<thead>
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<th>Description</th>
<th>Amount</th>
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<tr>
<td>Investments: Long-Term Restricted Fund</td>
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<td>CNS Endowment for Fellowships and Education</td>
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<td>Cash Reserves</td>
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<td>Fixed Office Assets</td>
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<td>Research and Development Fund</td>
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<tr>
<td><strong>TOTAL</strong></td>
<td><strong>$17,086,809</strong></td>
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**Table 2 > Main Expenditure Categories**

<table>
<thead>
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<td>CNS Fellowships</td>
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<tr>
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<tr>
<td>Operations Expenses</td>
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<td>Leadership Administration</td>
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<td>Information and Technology Projects</td>
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<td>Washington Committee</td>
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<td>Joint Section Support</td>
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<tr>
<td>Membership</td>
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</tr>
<tr>
<td>Publications (Editorial Office, Subscription, Other Costs)</td>
<td>$1,058,932</td>
</tr>
<tr>
<td>CSNS</td>
<td>$84,149</td>
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</table>
$8,498,561 for a net income of $415,589. Currently, the assets of the organization stand at a total of $17,086,809 (See Table 1). The costs centers for the organization are widely varied and include both operational expenses, fellowships, administrative costs and development expenses for educational products. Table 2 illustrates several of the main expenditure categories for Fiscal Year 2008.

Financial Policy
The CNS subscribes to a conservative investment policy. A large portion of the organization’s assets are held in two investment funds representing a long-term reserve fund and an endowment for fellowships and education. These funds are comprised primarily of stocks and bonds. The reserve fund is structured to preserve capital over the long term and promote slow growth and stability. The asset allocation is 40% equities and 60% fixed income. The endowment fund, on the other hand, is designed to provide more immediate financial support for grants and research as well as educational activities of the organization. The goal of this fund is to generate both current and future income at a slightly more aggressive pace. As with the reserve fund, preservation of capital is also an important consideration. This fund is inversely allocated at 60% equities and 40% bonds. The credit crisis and the downturn of the stock market have had some impact on the CNS holdings but to a substantially lesser degree than that of the leading market indicators such as the S&P 500 and the Russell 1000. Because our investment counselor, Crawford Investment Counsel, Inc. (Atlanta, Georgia) has helped us to select high quality bonds and stocks that have a higher than average dividend yield and attractive valuation, we have a fairly protective position for our investment portfolio.

Research and Development Fund
Since Fiscal Year 2007, a need was recognized to develop a fund with more liquid assets. The Executive Committee frequently encounters situations where rapid funding is required for a novel educational product. For this purpose, the Research and Development fund has been created with assets primarily held in a money market account. The current balance stands at $208,459. This fund is financed through direct transfers from the operational expenses throughout the year. The Project Coordination Committee authorizes short-term expenditures from this fund for product development with the anticipation that most projects will become financially self-sustaining over time.

Office Expansion
During Fiscal Year 2008, the central office underwent renovation and expansion to accommodate the growing infrastructure needs of the organization. The original budget for the project was $300,000 to include nearly doubling the physical space and acquiring capital assets such as furniture and computer equipment. The final cost of the expansion was $278,000 which was approximately 8% under budget.

New Initiatives
The Executive Committee has committed to several new educational initiatives including an expansion in scope of the CNS University. The CNS University is evolving into a hub for access to and archiving of educational resources. These include content from the Annual Meeting and topic-specific courses that have been created by the Education Committee. As the number of users increases, the need for financial support has also increased. Substantial funds have been earmarked over the next five years to grow this effort. In addition, the Executive Committee has decided to partner with The American Association of Neurological Surgeons to develop a Practice Outcomes Database that will subserve many of the regulatory needs for neurosurgeons today and in the future. The project is currently in its infancy but will ultimately require substantial financial support from both organizations for development and implementation. The Congress has committed to be an equal partner in this project and will expend a significant amount of money over the next five years.

Audit
The CNS undergoes an audit of its operations on an annual basis. This occurs typically in August after the books are closed for the preceding fiscal year. The audit serves two purposes: first, to document and verify the account balances in the various holdings of the organization and validate the stated assets; and second, to examine business practices and compare them to best practices throughout other industries and among other associations. This aspect of the audit is quite important to protect both the employees and the members of the organization. On both accounts, the CNS was given a positive evaluation this year and there were no issues identified that would be of substantial concern for the coming year.

The Congress continues to thrive as a member service organization and a provider of neurosurgical educational resources. It has been my distinct pleasure to serve the organization in the capacity of Treasurer for the last three years. My term has come to a close and I am grateful for both the responsibilities and the opportunities that this position has provided. I am certain that the organization will be in quite capable hands with its next Treasurer, Dr. Daniel Resnick.
In this, the 58th year of the Congress of Neurological Surgeons, it is my pleasure to present the Annual Secretary’s report. The last twelve months have been busy and successful ones for the CNS. As you will see, the CNS has done much over the last year to fulfill its promise of education and innovation. Thousands of the CNS volunteers have donated their time in support of these efforts.

For the last several years, under the direction of President Anthony Asher, the CNS has been engaged in a systematic reformation of Neurosurgical continuing medical education based on suggestions and feedback from the CNS members, the latest discoveries in adult learning theory, and consultation with outside experts in adult education. In order to coordinate this reformation, a Learning Sciences Subcommittee of the Executive Committee has been formed. With input from this committee, the CNS continues to expand its educational offerings, which now include the CNS Annual Meeting, Self-Assessment in Neurological Surgery (SANS), the CNS University of Neurosurgery, NeuroWiki and the Annual 3-D Surgical Anatomy Course for Senior Residents. All future educational offerings of the CNS will be developed within an integrated, objective and methodologically refined framework for learning. A renewed emphasis has been placed on the educational needs of Resident and International CNS members.

The Annual Meeting remains the premier educational offering of the CNS. The 58th Annual meeting, held in Orlando, Florida, from September 20-25, 2008, included groundbreaking science, dynamic speakers from within Neurosurgery and from without, and educational experiences not found anywhere else. The Annual Meeting has served as a showcase for new collaborative educational concepts, including Integrated Medical Learning®, Neurosurgical Forum and Consensus Sessions.

The CNS Publications Group has had a very eventful year. Under the direction of Editor Michael L.J. Apuzzo, *NEUROSURGERY*, the Official Journal of the Congress of Neurological Surgeons, has achieved an impact factor of 3.007, far exceeding that of its closest rivals. Clinical Neurosurgery, under the direction of Editor Gerald Grant, has published its first peer-reviewed volume. Congress Quarterly, under the direction of Editor Ali Rezai, has developed into the premier news magazine in Neurosurgery. Substantial reorganization has taken place within the
Publications Group, with all accounting functions moved to the Schaumburg office and all editorial oversight retained within the Los Angeles office.

Having recently completed a major expansion, the CNS Administrative Office continues to deliver exemplary member service. Under the guidance of Executive Director Laurie Behncke, this office has successfully facilitated an ever-increasing list of the CNS initiatives. In addition, since 2006 the CNS has skillfully managed the Annual Meetings of the Joint Section on Disorders of the Spine and Peripheral Nerves, the most successful meetings in Section history. All of this has been done with remarkable efficiency, allowing dues to remain the same as in 2003. At the 2008 CNS Annual Meeting, bylaws amendments were approved authorizing modern electronic communication regarding membership applications and proposed bylaws changes, allowing enhanced flexibility and increased efficiency within the office.

Membership in the CNS remains strong and continues to increase. There are currently 6,503 CNS members, including 3,017 Active members, 1,095 Resident members, and 491 Active International members. Growth continues in the International Vista membership category, with 312 neurosurgeons currently enjoying the benefits of this newly-created category. The current meeting has seen the creation of a Medical Student membership category, developed to help attract the best and most qualified students to Neurosurgery upon graduation. Membership in the CNS remains a great value and more important than ever in the rapidly changing environment in which neurosurgeons practice. Members benefit from opportunities for learning, professional service and networking. Active membership in the CNS includes complimentary subscriptions to three premier CNS journals, reduced prices for Annual Meeting registration and SANS, and access to expanded internet content and services. In addition, the CNS membership supports the Washington Committee, co-owned, co-funded and co-managed with the AANS. Under the direction of Ms. Katie Orrico, the Washington committee deftly advocates for all of neurosurgery on a local, state and national level.

In conclusion, the CNS has had a very good year. We thank Dr. Asher for his service and leadership over the last twelve months and welcome Dr. P. David Adelson as the new CNS President.
Two-thousand eight has been a banner year for the CNS Resident membership. Membership is at an all-time high, at just under 1,100 resident and fellow members. Resident and fellow volunteerism within the organization continues to grow, from the Annual Meeting Sergeant-at-Arms program to active committee involvement across all levels. There have been rave reviews for the CNS-sponsored educational programs, especially the Senior Residents 3-D Anatomy Course hosted by Dr. Saleem Abdulrauf at Washington University, St. Louis. Both North American and International Members continue to pursue a dizzying array of high-quality research and clinical fellowships through the CNS research and training grants. The year culminated in our annual showdown of the fastest six-slinger of neurosurgical knowledge—the SANS (Self-Assessment in Neurological Surgery) Resident Challenge. Finally, in keeping with the CNS’ goal to increase international exchanges of knowledge, experience and collegiality, the CNS will be adding an International “Vista Resident” category in 2009.

The Congress Resident and Fellow membership stood at 1093 persons at the end of the 2007-2008 academic year. Unlike other membership groups, the resident and fellow membership fluctuates at the transition in July, when graduating residents and fellows become transitional members and new residents have not yet applied for membership. Over the past 5 years, resident membership has grown nearly 30%, averaging just over 6.5% per year for the past 5 years. (Figure 1) Each year, we continue to add a few more members than there are new residents, indicating that the total proportion of residents and fellows training in North America continues to grow. (Figure 2) Currently, over 79% of residents training in North America choose to become members of the Congress of Neurological Surgeons.

This year’s SANS Resident Challenge was a phenomenal success. Similar to previous years, residents from nearly one-third of all

Figure 1 > Total annual resident and fellow membership in the Congress for the past five years.

Figure 2 > Annual new members in the Congress for 2004-08.
residencies across the country participated in an online qualifying round during the month of July. From this pre-test, the nine highest scoring programs were identified. Each program was invited to send two representatives to compete in the live rounds, which were held on Sunday afternoon of the Annual Meeting. There were three full “jeopardy-style” matches, resulting in one winner from each match proceeding to the championship round. This year the championship round included residents from the National Capitol Consortium, Stanford University and University of Colorado. In an extremely close match-up, University of Colorado won first place during Final Jeopardy after correctly identifying - “the 8 muscles innervated by the Trigeminal Nerve.” Congratulations to Colorado, along with Stanford who took second place and NCC who took third. (Figure 3)

In keeping with the Congress’ strategic plan to increase the CNS’ international presence, we are pleased to introduce a new membership category in 2009. This past year, we have seen new membership categories for International Vista Members and Medical Students to increase our opportunities to serve these two important groups within the world of Neurosurgery. The next step is to extend resident membership to all trainees worldwide. This new category, Vista Resident, will be available to all trainees outside of North America (which is defined by the Congress as the U.S., Canada and Mexico). Vista Residents will be required to furnish proof of training from their program director and their membership will be automatically converted to transitional status upon reaching their expected date of graduation. Vista Residents will receive electronic access to NEUROSURGERY, Congress Quarterly, Clinical Neurosurgery and many other electronic educational resources, including the CNS NeuroWiki and the CNS University of Neurosurgery. Vista Residents will also qualify for resident education programs and subsidized housing and registration at the Annual Meeting. This new category will be launched in conjunction with the 2009 New Orleans meeting.

We are looking forward to welcoming resident and fellow members worldwide to the Congress and we can think of no better way to celebrate than to kick-off with the First Annual International SANS Resident Challenge in New Orleans. Through our 2009 Annual Meeting Partner, Neurological Society of India (NSI), we have invited training programs from India to participate in the 2009 qualifiers, and together NSI and the CNS will sponsor the travel and boarding costs for a team from their top program to play in the live rounds in New Orleans!

Finally, we would like to thank Michael Steinmetz for his guidance and support as Resident Committee coordinator over the past few years and welcome Catherine Mazzola as the new co-coordinator of the Resident Ad-Hoc committee. Catherine will continue Michael’s work in recruiting and retaining resident and medical student members and increasing opportunities for residents to volunteer.

If you or someone you know would like to become a Resident or Fellow Member, we encourage you to apply online at http://mbr.cns.org/Application/SignIn.aspx or e-mail us at info@1cns.org today!
The CNS continues to be a premier national and international conduit for the advancement of neurosurgical education. The CNS has charged its Fellowships Committee to oversee the recruitment and disbursement of monies to promote educational pursuits in identified strategic areas of neurosurgery. During the past year, the CNS Fellowships Committee has engaged in an earnest effort to increase the breadth and scope of sponsored educational activities for medical students, residents and fellows in hopes of promoting career development, scientific advancement and improved patient care.

This year was a record-breaking year for the Fellowships Committee in many ways. It passed the $300,000 mark for disbursed fellowships. Similarly record breaking was the number of applicants for these highly competitive awards, including 78 domestic applicants from the United States and Canada and 25 other international applicants. This represents a 37% increase in domestic applicants and a 130% increase in international applicants. The application process included a comprehensive review by individual committee members with a variety of expertise who scored all applications, resulting in an aggregate score for each applicant. This was followed by an exhaustive deliberation for each award, leading to the selection of candidates presented to the CNS Executive Committee for approval.

The three CNS-sponsored clinical awards — the Penfield, Dandy and Cushing fellowships — went to Edward Chang from UCSF, Chirag Patil from Stanford University, and Jody Leonardo from University at Buffalo, respectively. These awards collectively total $90,000 per year. The CNS-sponsored Basic/Translational Research Young Investigator fellowship was awarded to Johnathan Engh from the University of Pittsburgh, while the Resident Award went to Christopher Iannotti from the Cleveland Clinic. These two awards total $40,000 per year. The CNS Charles Plante Public Policy fellowship was awarded to Joseph Hsieh from the University of Chicago. This award provides up to $80,000 for two years. The CNS Functional Neurosurgery Fellowship in the amount of $10,000 was awarded to Timothy Lucas from the University of Washington.
The CNS also selected four awardees for the CNS-sponsored medical student summer fellowships, totaling $12,500. This year’s recipients are Claudia Berrondo from Dartmouth, Claire Olson from UVA, Doniel Drazin from Albany Medical College, and Sohum Desai from Texas A&M University.

The largest group of fellowships this year is made available through our corporate partners. The CNS offers them an optimal opportunity to help advance neurosurgical education in line with their educational missions and interests, as well as provides a peer-reviewed application process that maintains the highest compliance standards with industry relationships. This has resulted in an increase of four new fellowships for the year 2008. The current company-sponsored awards include the CNS Medtronic Spine Fellowship: Deb Bhowmick, University of Pennsylvania; CNS Micrus Endovascular Fellowship: Cian O’Kelly, University of Toronto; CNS Boston Scientific Fellowship for Cerebrovascular Research: Hayan Dayoub, University of Oklahoma; CNS/ASAP Hydrocephalus Award: Spiros Blackburn, University of Washington; CNS Synthes Spine Fellowship: Gregory Hawryluk, University of Toronto; and the CNS/MGI Pharma Fellowship in Tumor Research: Abraham Boskovitz, Tufts University. These five awards totaled $145,000 per year.

The CNS is committed to advancing international neurosurgical education by maintaining a vital cohort of CNS fellowships. To this end, four awards were disbursed this year to merit-based candidates from our international pool of applicants. This included the CNS Lars Leksell fellowship awarded to Thomas Flannery from Northern Ireland; the CNS George Ablin fellowship won by Sanjay Gupta from India; the CNS Kenichiro Sugita awarded to Luis Bolivar Moscote from Columbia; and the CNS/CINN Foundation awarded to Wenhua Zhang from China and Varun Bhargava from Guyana. These international awards totaled $45,000 per year. All of the awardees were given official recognition at the recent 2008 CNS Annual Meeting during General Scientific Session I.

The goals of the CNS Fellowships Committee for 2009 are to increase the fellowship awards by 10% and the applicant pool by 30%. We have already met and will undoubtedly exceed our goals for total awards disbursed. We continue to negotiate with the five prospective sponsors for their commitments. We disbursed up to $380,000 in fellowship awards in 2008 and are on target to break the $500,000 barrier in the years ahead.

The CNS Fellowships Committee is also working diligently to increase the number of applicants for these very precious resources. As was noted by all committee members, the caliber of the proposals was outstanding, particularly from our domestic applicants. No doubt we are increasing the pool of physician scientists in our neurosurgical residents. This certainly augers exceedingly well for our future as an advancing, ever-improving specialty that serves the community with distinction and excellence.

We have informed all neurosurgery program directors in North America of the exciting opportunities for their residents to engage in research and clinical excellence. Further, we plan an aggressive advertising campaign to increase awareness throughout the potential applicant pool for the coming year’s application process, which is available and detailed on-line at the CNS web site http://www.cns.org/education/fellowship.asp. We urge all to visit the web site and encourage residents to avail themselves of this truly unique opportunity.
Project Shunt 2007 celebrated its tenth year of providing neurosurgical and medical care to the children of Guatemala. Sponsored by Healing the Children and the Fundación Pediátrica Guatemalteca, this year’s team of 26 members included Drs. Karin Muraszko, Hugh Garton, Suresh Ramnath, Nicholas Boulis from Emory University, and three residents from the University of Michigan Department of Neurosurgery. We were also fortunate to have Dr. Steven Buchman, Chief of Pediatric Plastic Surgery at C. S. Mott Children’s Hospital in Ann Arbor, join us to assist in the complex wound closures of patients with extensive neural tube defects.

The day after we arrived in Guatemala City, work began with one part of the team evaluating patients in clinic and the other group setting up three operating rooms and the recovery area at the hospital. Each year, Project Shunt brings all of the equipment and medicines needed to run its own operating and recovery rooms—everything from patient monitors, IV fluids and sterile operating gowns to instrument sets, linens and portable sterilizers. Fifty boxes of supplies were shipped to Guatemala two weeks prior to our arrival; the rest of the equipment was taken down with the group in 25 foot lockers. After an extensive renovation and remodeling process lasting several years, the Fundación Pediátrica Guatemalteca’s Nino Jesus Hospital reopened this year in Guatemala City. Gone are the days of operating in tiny, cramped operating rooms under flashlights during intermittent power outages with the occasional cockroach scurrying across the floor in sweltering heat and humidity. We were pleasantly surprised to find a new and improved hospital setting.

Back at the clinic, the waiting room was flooded by dozens of patients and their families. The scene was punctuated by the rich, bold colors of traditional Guatemalan garments. Scanning the clinic, I was struck with a combination of awe, gratitude and humility in realizing the great sacrifice and risk families had undertaken just to have the chance to meet with the members of our team. This fall has been a particularly precarious and trying time for the people in Guatemala. Just weeks prior to our arrival, the national elections took place and were marred by unprecedented levels of violence and corruption. In addition, three weeks before, Hurricane Felix brought rainstorms and rendered many of the roadways leading to the rural towns and villages impassable. Despite these circumstances, families traveled for hours and through difficult conditions to make it to our clinic.

As a team, we worked efficiently and thoroughly to see over 45 patients in the span of 6 hours. Some of the cases were heartbreaking: a child with a very large unrepaired myelomeningocele and massive hydrocephalus whose mother carried him around covered in a blanket from head to toe. She pleaded with us that she just wanted to see the child’s eyes, which were seemingly fixed in a sundowned state. Others were children with tethered spinal cords who were losing leg function. Perhaps most gratifying was the return of two patients from Project Shunt 2006 who were now thriving after their operations.

As the case complexity increases each
year, the importance of Project Shunt becomes ever more apparent; these technically challenging operations would likely not happen were it not for the mission. This year, we performed 17 operations, including two myelomeningocele repairs, two terminal myelocystocele repairs, three lipomyelomeningocele repairs, and two complex split cord malformation repairs. Operations often lasted until the early evening, with families waiting patiently in a makeshift waiting area. Many of the families were brought to tears after being assured that all of the care was free and that all of the postoperative medication would be provided.

After the children got out of the operating room, they spent a few hours in the recovery room under the watchful team led by Dr. Gail Annich, a University of Michigan pediatric critical care intensivist, before being transferred up to their rooms for the evening. During morning and evening rounds, we also got a chance to interact with the Guatemalan nurses and pediatricians, as well as the Guatemalan neurosurgeon who will be following up with all of the children following the completion of Project Shunt.

Beyond the operations, Project Shunt also distributed countless amounts of toys, clothes, toothbrushes, Spanish educational materials and food to the patients’ families. We also continued a critical component of our mission: teaching families an aggressive catheterization regimen for children with spina bifida who may have bladder dysfunction and in whom urosepsis may be fatal. We were able to donate a year’s supply of catheters to patients’ families. Each member of Project Shunt also made a personal monetary donation to support the purchase of Guatemalan handicrafts that will be sold in our upcoming fundraising sale.

I am grateful to all of the doctors, nurses and supporters who helped make Project Shunt 2007 a success. Project Shunt relies entirely on donations and our fundraising sale so the mission would not be possible without the generosity of donors and the dedicated efforts of our volunteers. Despite the fact that the facilities in Guatemala do not compare to the University of Michigan and the conditions are not always optimal, I am confident and proud of the fact that Project Shunt 2007 has been able to offer truly outstanding medical care from the very best that the University of Michigan has to offer: four neurosurgery faculty and three residents, two anesthesiology faculty and three senior level residents all experienced in critical care, two pediatric ICU attendings and one pediatric critical care fellow, and some of the most highly skilled and experienced OR and ICU nurses at the University of Michigan Medical Center.

I am extremely proud to have been able to be a part of Project Shunt during my residency. I learned how to equip and run an operating room from concept to completion and it has made me a better surgeon. In addition, it has fostered a broader view of health care which will impact the way I provide care in my own community back home. And I also like to think it demonstrates in a very real way that people in the United States care about the world outside our own borders, an impact that should not be downplayed, particularly in this day and age.

2007 Project Shunt members:

Neurosurgery — Karin Muraszko, MD; Hugh Garton, MD; Suresh Ramnath, MD; Nicholas Boulis, MD; Hunter Brumblay, MD; Debbie Song, MD; Daniel Orringer, MD

Plastic Surgery — Steven Buchman, MD

Anesthesiology — Brian Woodcock, MD; Judy Negele, MD; Robert Christensen, MD; Nicole Jeffreys, MD; Derek Woodrum, MD

Pediatric Critical Care — Gail Annich, MD; Timothy Cornell, MD; Patricia Raimer, MD

Recovery Room nursing — Catherine Walls, RN; Elvia Parker, RN

OR personnel — Jacqueline Haaseth; Yvonne Bellairs, RN; Bruce Macnee, RN; Sara Stump; Patricia Dean, RN; Cristian Dowe; Suzon Macnee

Team Aide — Scott van Sweringen
Stroke is the third leading cause of death in the United States, behind heart disease and cancer. In 2004, 150,000 people died of stroke. This is reflective of an incidence of 700,000 in 2004, with an estimated prevalence of 5.7 million during the same period. Of these strokes, 87% are ischemic; the remainder are a combination of intracerebral and subarachnoid hemorrhages. Ischemic strokes principally are made up of large-vessel thrombosis (40%), atheroembolic disease (37%), and lacunar-small vessel disease (23%). Therefore, up to 77% of ischemic strokes may be potentially amenable to intra-arterial therapies. In 2004, this would have potentially amounted to 470,000 patients. As a comparison, carotid endarterectomy, one of the most common surgical procedures, was performed 100,000 times during the same period (National Hospital Discharge Survey [NHDS]).

These staggering numbers are indicative of the epidemic proportions of stroke. Besides the 25% mortality rate, this disease leaves 26% of survivors institutionalized in nursing homes and an additional 25% dependent to some degree in carrying out the activities of daily living. Overall, stroke is the leading cause of serious long-term adult disability. The cost to society in 2007 is estimated at $63 billion.

Despite the increase in education and the results of the National Institute of Neurological Disorders and Stroke (NINDS) intravenous thrombolytic therapy trial, the median presentation for patients to the emergency room remains between 3 and 6 hours after symptom onset. This delay in presentation, in addition to the contraindications to intravenous thrombolysis, means that less than 5% of patients receive intravenous thrombolysis. Further analysis suggests an inverse relationship of the effectiveness of intravenous thrombolysis to the severity of the stroke (National Institutes of Health Stroke Scale [NIHSS]), with up to 60% of patients left dead or severely disabled, despite receiving intravenous thrombolysis. For patients who are ineligible to receive intravenous thrombolysis, potential has clearly been demonstrated for endovascular treatment with intra-arterial thrombolitics (Prolase in Acute Cerebral Thromboembolism II [PROACT II] trial) and intra-arterial mechanical thrombectomy devices (Mechanical Embolus Removal in Cerebral Ischemic [MERCI] trial and, more recently, the IMS II and III and Penumbra trials).

The astronomical statistics related to the stroke epidemic have been noted by health care administrators as well as by specialty groups and industry. There is an intense ongoing effort directed at diagnosing and addressing the major risk factors for stroke. Risk factors such as previous stroke or transient ischemic attack (TIA) are being aggressively evaluated to address underlying cardiac and extracranial as well as intracranial disease. It is known that the 90-day stroke risk after a TIA is as high as 18%. One year after a TIA, 25% of patients are dead. These somber figures have resulted in evaluation of carotid endarterectomy and, more recently, carotid angioplasty and stenting for reduction of the risk posed by extracranial carotid disease. Similarly, the Warfarin-Aspirin Symptomatic Intracranial Disease (WASID) trial...
has demonstrated an up to 40% risk of recurrent stroke after discovery of symptomatic intracranial stenosis. Certainly, these results have created a demand, both academic and industrial, to evaluate the efficacy of endovascular management for this disease.

In view of the rising tide of stroke and its resultant morbidity and mortality, estimates project that the deaths caused by stroke will likely increase almost 100% within the next 30 years, despite a concurrent rise in population of less than 30%. In response to these alarming statistics, the Centers for Medicare and Medicaid Services (CMS) has announced robust revisions and new codes for the reimbursement of management of acute stroke. These changes reflect a keen observation of constantly accruing data, which suggest promise in intervention. As of October 2006, the CMS announced new codes and revised Medicare payments. Medical management of acute stroke (completely void of mechanical or pharmacological thrombolysis) pays about $5,500. This increases to approximately $12,000 following either intravenous or intraarterial thrombolysis. A new DRG code, 543, has been established for utilization of mechanical devices for thrombectomy. This latest code brings the Medicare national average to $23,000. Similarly, a new ICD-9-CM procedure code, 39.74, has been designed for “Endovascular removal of obstruction from head and neck vessels.”

Referring back to our original analysis, with 610,000 patients suffering ischemic strokes and a large proportion potentially eligible for intraarterial therapies in 2004 and this number expected to double over the next 30 years, a major concern is created for those who reimburse for health care. The cost of an upfront treatment that reduces long-term disability provides major financial incentives, which are beginning to be recognized. A large proportion of the $63 billion cost in 2007 is attributed to chronic care and lost productivity. Therefore, improving reimbursement, at least at the hospital level, has created vital financial incentives for the industrial development of endovascular strategies for acute stroke management. The NIH has similarly outlined an aggressive program for funding stroke research, cognizant of the epidemic proportions of this very costly disease and its aftermath.

As neurosurgeons, it is important for us to recognize that trials like the International Subarachnoid Aneurysm Trial (ISAT) and the International Study of Unruptured Intracranial Aneurysms (ISUIA) have changed the landscape of aneurysm management, with a strong shift towards endovascular techniques. That being said, approximately 30,000 aneurysms rupture in the United States each year. This number represents only 6% of possible acute stroke interventions. Endovascular expertise is currently shared among select neurosurgeons, neuroradiologists and neurologists. A smaller number of cardiologists are also beginning to fill the large void in acute stroke care. Interventional cardiologists have the tools and the mind set for acute endovascular intervention; they also happen to far outnumber the neurological contenders. Simply stated, with clear evidence of improving efficacy of endovascular treatment, epidemic proportions of disease, astronomical costs of inaction, and continuously improving financial incentives for intervention, somebody will be doing acute stroke. A safe bet would be that once comfortable with acute intracranial intervention, anatomy and endovascular technology, those clinicians treating acute strokes will also be treating aneurysms, arteriovenous malformations and other neurovascular conditions.

Epidemiologic prevalence of this terrible, devastating and costly malady, in conjunction with improving reimbursement, should provide fertile ground for a major paradigm shift in neurosurgical training for the future. We will need many more than a few endovascular fellowship-trained neurosurgeons to address the manifest needs. Our retired chairmen remind us of all those carotid punctures for diagnostic cerebral angiography that they performed as residents in the 1950s and 1960s. Perhaps all neurosurgeons need to be facile with endovascular techniques, at least to the extent of acute stroke interventions. Maybe then, we will be able to fulfill the needs of the community and possibly avert losing all vascular neurosurgery to other specialties.
By the time you read this editorial the Presidential election will be over. Now, there will be an intense focus on healthcare. The decisions that are made will be crucial to the future of medicine, your practice and your patients. It is important for physicians to get some fundamental facts correct first so that they can discuss the issues correctly. These are the facts you should know.

1) This is the story behind the claim that 47 million people in the U.S. do not have health insurance. This statistic, often quoted by politicians and medical publications (including the lay press), is inaccurate. The figure is determined by one question asked by the Census Bureau during a census to anyone in the home who will answer: “Do you have healthcare coverage now?” The answer is “Yes” or “No.” In actual fact, in a more detailed study by the Census Bureau, about two-thirds of the uninsured are in and out of work for a year and 45% of those people lack healthcare coverage for four months or less. Twelve million people do not want insurance even if they are eligible. One-half of uninsured adults are under the age of 35. Many young people do not choose to have healthcare insurance and are not covered. Many of the uninsured earn more than $50,000. Immigrants represent 86% of the growth in the uninsured. Actually, only 23 million people lack health insurance by a study reported in Health Affairs in 2007, one half the number commonly reported in the press. This figure is 7.7% of the USA population. So, 92% of the USA population has health insurance.

2) The high infant mortality statistics in the U.S. compared to those of other countries are based on comparing statistics without a standardized means of recording. In most countries, newborn deaths are declared as stillborn. Japan records infant deaths as stillbirths. In Switzerland, infants must be 12 inches long at birth to be declared “live”. In Canada and Australia, one-third of the deaths are reported to occur in the first day while in France and Hong Kong, 16% and 4% of deaths, respectively, reportedly occur within the first day. Even the World Health Organization says that the definitions of infant mortality are different all over the world. Why are there these differences? In the U.S. everything is done to save newborns. This is a tribute to a healthcare system and should not be a criticism. Let’s compare what other countries do with premature births and low birth-weight infants with the same statistical measures we use in the U.S. The statistics do not even make common sense. Similar data errors occur comparing life expectancies. There are also many variables in these statistics. What would you think if a neurosurgeon competitor said he/she had no complications in spine surgery? Would you believe it? You would want to look at their statistics and make sure that they were reporting the same things that you are. Why do we accept these statistics about healthcare without questioning the data?

3) The claim that auto industry employees’ healthcare adds $1,500 to the cost of each automobile and reduces the competitiveness of U.S. manufacturers is also not correct.
During the years when SUVs were hot sellers, the healthcare costs were the same and there was little complaint about these costs from the auto companies while they made 4%-5% profits. With dealer incentives, the prices of American cars are lower than those of foreign-made cars and still the public will pay more for the foreign automobiles. The real problem is that the public is buying more foreign-made automobiles because the foreign autos are more appealing and economical, even though the cost of foreign cars is higher. So, let’s not blame the healthcare system for the failures of business strategy and execution in the automobile industry.

4) The 98,000 deaths attributed to medical errors in our hospitals each year is also incorrect. The figures are extrapolated from a very small study that was not even intended to ask the question about medical errors, and the figure may be grossly overestimated. Let’s have a real study that is designed to answer that question.

5) I have seen no socialized medical system in the world that is working. There are waiting lines for care, and deaths occur while waiting for this care in every socialized system in the world. There are limitations on the choice of drugs and devices for patients and runaway costs in socialized systems including England, France, Sweden, The Netherlands, Germany, Canada and others. Patients are dying waiting for care and patients with minimal complaints are clogging doctors’ offices preventing others from being seen. Why? Because healthcare is FREE! The costs of a socialized medicine are bankrupting the budget of Quebec. The former minister of Health who designed the Canadian Healthcare system 40 years ago says that socialized healthcare is a failure in Canada. Patients who can afford to leave these countries get care elsewhere. The government has become the doctor in these socialized countries and, like any bureaucracy, is doing badly managing the system. Our V.A. hospitals are an example of government care. What about the recent complaints concerning Walter Reed Hospital and the care for Iraq veterans? The problems are the same in any socialized system. Our government has not resolved the energy crisis after 30 years and its inaction has resulted in high energy costs and our dependency on foreign powers. Our elected politicians have not solved the immigration issue. Medicare and Social Security are headed for bankruptcy, but the politicians deny this fact and fail to act. How can the government be expected to deal with your patients’ personal healthcare problems? Will some politician or appointed bureaucrat decide what to do with your patients’ healthcare issues? Is this what your patients want?

6) Fifty percent of all deaths each year in this country are related to auto accidents, drug abuse, guns, sexually transmitted diseases and alcoholism. These are social problems, yet the healthcare system is held financially responsible for the outcomes of such unresolved social problems. The illnesses that these problems create place economic stress on the healthcare system and the doctors and nurses who care for these patients.

7) The rising costs of healthcare can be attributed to everyone trying to game the system to make money. Insurance companies, hospitals and healthcare businesses are the major abusers. With them are the politicians, who have passed legislation restricting the freedom of patients and doctors, while every other person in the country has the freedom to engage in personal business transactions without excessive regulation. What is broken is the record of government regulations that have created a system that does not work. Look at the restrictions that prevent doctors from developing specialty hospitals and other business ventures. Look at the immense paperwork doctors are required to do to practice in the system, amounting to wasted time that could be spent on patients. There are estimates that 30% or more of the healthcare budget for Medicare is spent on administrative costs. What about costs every doctor has assumed in adding staff to deal with payments from insurance companies when bills should be paid immediately? What business allows customers to delay payments for months without penalties? Let the free market decide the outcome of healthcare. Regulation has led to increased costs and less care as is seen in socialized medicine systems around the world. Is this what everyone wants? We need a system with open competition that allows creativity among physicians and other healthcare providers to reduce costs. The marketplace works if we let it. Socialism and governmental controls do not.

8) Unfortunately, doctors have been made the scapegoat for many social and political problems and they have not responded appropriate-
ly nor have their medical societies. Their silence is viewed as acquiescence. A good part of the problems in medicine is the fault of doctors who do not stand up to defend themselves and medicine. Everyone knows the doctor will take whatever he/she is told and not object. What would you do if you were on the other side? If they can get away with treating doctors to their disadvantage, they will do more of the same. That is what we have all seen for years. The capitulation seen by doctors around the country to the disinformation on healthcare is wrong.

9) If healthcare costs are to be controlled, let’s apply the formula across the board. Healthcare businesses, pharmaceutical companies and instrument makers should have defined limits on the profits they make and limits on the money paid to their executives. Hospitals should also have limitations on salaries for administrators and on hospital profits. Legislators should receive the same cuts in their incomes that doctors do. Doctors’ incomes have actually declined in the past 10 years, while others have risen. (By the way, the Democratic party is not far from proposing some of the socialized recommendations stated here and you know such socialistic changes will not be enacted against businesses.)

10) Two-thirds of the country’s population is overweight. Is that the fault of doctors? No. It is a symptom of a society that will deny itself nothing. Obesity also extends to the poor. What does this problem mean for doctors compensation in the future? With added costs to take care of the overweight people, the doctors’ pay would be reduced.

11) Healthcare is not a right; it is a choice that people have the freedom to make for themselves. If people believe that they have a right to your knowledge, you have a right to refuse. No profession is regulated as much as medicine. No wonder the quality of applicants going into medicine has declined over the years—it is not as attractive a profession as it once was.

12) What needs to be done? A.) Health insurance should be owned by the citizen. If a company wants to provide the benefit to choose that insurance, then the employee can decide what plan they want for themselves, but will own the insurance. Health insurance should be portable. For those who cannot afford insurance, they should be given vouchers or credits by the government to buy that insurance. The free market should be preserved. The healthcare contract should be between the patient and the doctor, but not a disinterested third party and the doctor. We have credit card medicine with runaway costs. Would you expect anything different in a credit card system where someone else is paying the bill? B.) Medicare should be for those who cannot afford health insurance. It makes no sense to have the poor pay for the healthcare of the rich. There should be a means test for Medicare. C.) There should be a scaled premium for health behavior as in auto insurance. Meeting good health standards should be rewarded with lower premiums. The change will incentivize healthy behavior. Patients who are overweight, have uncontrolled hypertension, diabetes and who smoke should have higher premiums. Make the public responsible for its health. Nearly 100 percent of the population has TVs and VCRs. Where are the priorities? D.) Health savings accounts are working. Make them more available. E.) Close the borders to immigrants. Would you allow anyone to come into your home and settle there? After closing the borders we have to deal with those who are here illegally—which affects healthcare costs for all of us. F.) For those who are self employed, let them have the same tax credit for health insurance that large companies enjoy for their workers. Let’s make the playing field fair and equal. G.) Nationally, solve the malpractice crisis. Let’s reduce the paper work and bureaucracy. Increase the payments to doctors and more people will be attracted to medicine as a profession. I.) Fine insurance companies for payments to physicians beyond 30 days, or require a deposit by the insurer before the service is rendered. Why should physicians wait to be paid when executives and legislators receive their pay regularly?

13) With the coming shortage of doctors and nurses, the shortage of hospital beds, and the rising demands for healthcare of the aging population in the country, how can one expect a universal system to work? There is a shortage of neurosurgeons around the country. We cannot staff all the emergency rooms that want our services now. Why did that occur and how do you solve that problem? The state of California just reduced the MediCal (Medicaid in other states) payments to doctors. Doctors are refusing to care for these patients because by doing so they are operating at a financial loss. Why would doctors want to care
for this population while losing money doing it? Are physicians being singled out to solve your state’s budget deficit because the lawmakers showed no fiscal responsibility?

14) The American healthcare system is the best in the world. Even with the flawed figures of 47 million uninsured, the system covers over 85 percent of the population. With the correct figures of 23 million uninsured, that is over 90% of the population that is covered in the USA. So, why is there a rush to throw out a successful system in exchange for a plan that will be a certain failure? Is that what the public wants? Let’s improve the parts of our present system that do not work. I sure don’t trust a politician to make my life choices. Do you? This is what’s happening in the countries of Europe with socialized medicine. In England the government found that too many caesarian sections and epidurals were being done. So, the government said that women should deliver their children at home without epidurals but with midwives. That is 1900s medicine! Neither the doctor nor the patient is involved in this choice. The government is the doctor. Is that what your patients want? It will certainly happen here with universal healthcare or whatever it is called. Let each person decide what he or she wants to do with their life and their children’s lives, not some bureaucrat or politician.

15) What about the argument that physicians are supposed to take care of patients without regard for money to follow the Hippocratic Oath? This argument is often used as a means to make physicians feel guilty. Most physicians receive only a fraction of what they charge insurance companies, from 20%-40% in most cases. So doctors are giving from 60%-80% of their incomes away to help patients. There is no other profession in the world that gives this kind of charity to help others in need. Doctors are the most charitable people in the world but never get credit for their gifts to others. The business people make money (without deductions from revenue) and then give the money away to obtain huge recognition from society. Physicians who give away more of their earnings than any other profession are never credited with their generosity. If medicine is to attract the brightest and best people to become doctors, there have to be the proper incentives both personal and professional to have the best physicians care for the population. What kind of doctor does your patient want to care for them? How do they think we can attract those people to be their doctors?

16) Physicians have the most powerful lobby in the country, in their offices, every day: the patient. Take a minute during each visit and explain one of the points above to the patient. Let them know that you receive 20 cents on the dollar from Medicare and not much more from the rest. Medicaid payments may not even be paid in your state, although the government promises to pay the bill, so, you may receive nothing for caring for the indigent. Let the government treat businesses the same as it treats doctors and see how popular that will be. ‘We can’t make any money that way,’ they will say. So, why is it wrong for a doctor to say the same thing? Ask your patients if they want the politicians to make their healthcare decisions, or do they want to decide what to do for themselves?

17) What physicians need to do is to get the facts straight and to offer sound proposals to solve the problems about healthcare. We are highly educated scientists. Why do we blindly accept information that is untrue? Who is standing up for medicine? Physicians are the only ones who have the patient’s concerns as a priority. The rest are interested in profits, not in the patient.

I would be happy to come and address your hospital’s medical staff on these issues. We need to get the message out. Call me, and I will be there.

You may get references for the points made in this editorial on request from jamesausman@mac.com.
Congress of Neurological Surgeons is inviting applications for the position of Editor-in-Chief, NEUROSURGERY®.

The Congress of Neurological Surgeons is pleased to announce that it is inviting applications for the position of Editor-in-Chief of NEUROSURGERY®. The new Editor-in-Chief will be selected by the CNS Executive Committee at the conclusion of a comprehensive international search process.

NEUROSURGERY® is widely recognized as one of the most outstanding scientific and medical journals in the world. In selecting the new Editor-in-Chief, the CNS seeks to maintain the excellence of the journal and advance its proud history.

Applicants for this position should be neurosurgeons certified by the American Board of Neurological Surgery or equivalent. They should have significant experience in medical publishing, as well as some familiarity with financial and total quality management. Additionally, applicants should have a record of independent scholarly accomplishment.

Interested individuals should provide a current curriculum vitae and vision statement to the CNS. Details regarding the full application process and related job description are available at www.cns.org/editor.

For additional information, contact the CNS at info@lcns.org.

Applications should be completed by no later than February 27, 2009.

We encourage all qualified individuals in the international neurosurgical community to apply for this important position.

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Applications and eligibility requirements are online at www.cns.org.

From its very inception the Congress of Neurological Surgeons was intended and conceived as an international organization. It is not exaggerating to say that the CNS is genetically programmed to be international in vision, scope, membership and services.

Insights into the thinking behind this assessment can be taken from Dr. James Gay, Past-President of the CNS and a Founding Member. His writings include the rationale behind the organization’s name: “The Founders avoided limiting words like American or National, or North American because they envisioned the society to be worldwide in scope. The word Congress was all inclusive—American, European, Asian, South American (intercontinental).” That genotype has found phenotypic expression in a variety of ways over the last half-century and more.

Fast forward to today as the world is in the throes of a macro trend of globalization from several inexorable flattening forces. Organizations such as the CNS can leverage these forces and capitalize on the potential advantages. Given this trajectory, one might say that the CNS founding fathers were prescient in their strategy of internationalism.

This article on international involvement begs the question, what is the nature of the CNS’ international involvement? One might rightly argue that it started at the very top, finding immediate expression in the selection of the first three CNS Honored Guests who were international neurosurgeons: Herbert Olivecrona (1952, Sweden); Sir Geoffrey Jefferson (1953, UK); and Kenneth McKenzie (1954, Canada).

A further initiative was the steady expansion of the member base to where today there are members in almost every corner of the globe. More recent evolutions in membership include the creation of the International Vista category to complement the International Active members. International members have served as CNS Ambassadors, Committee Members, Executive Committee Members, Journal Reviewers and on the Editorial Board, thereby contributing their valuable assets to the service of the organization.

Education, the lynchpin of the CNS mission, has long been closely tied to internationalism. Witness the international attendance at the Annual Meeting at the registrant, faculty and society level. Individual international registrants participate in, contribute to and benefit from the educational offerings at the Annual Meeting. On a more macro level joint society meetings between the CNS and national, regional and continental societies have gone from novelty to routine. They have included meetings in the U.S. and abroad. A few recent examples demonstrate this trend. A joint meeting in Paris, France in 2002 between the SNCLF (Societe de Neurochirurgie de langue Francaise) and the CNS was followed by the invitation of the SINcCh (Societa Italian Neurochirurgia) to the San Francisco, California 2004 CNS Annual Meeting. The SINcCh reciprocated by hosting a joint conference in Rome, Italy in 2007.

The CNS Annual Meeting in Boston, Massachusetts in 2005 expanded the stage to an invitation to the continental European Association of Neurosurgical Societies (EANS), and in turn the EANS reciprocated by hosting...
the CNS at its meeting in Glasgow, Scotland in 2007. The German Society was our guest in Chicago 2006. In 2008 alone, the CNS was the guest society at the Croatian Neurosurgical Society in Dubrovnik and hosted the Brazilian Society in Orlando, Florida at the CNS Annual Meeting. This trend is poised to continue for the foreseeable future for the obvious reasons that it fosters scientific, cultural and social exchange and most importantly fulfills key twin missions of the CNS—internationalism and education.

Bolstering the education offerings are the opportunities for extended interaction provided by the CNS International Fellowships. Vital mentorship, lifelong friendships and international institutional networks have been created as a result of this program. The value of the fellowships extends well beyond the direct benefit to the individual education of the fellow.

Perhaps no other single CNS product epitomizes the international involvement better than NEUROSURGERY, the official journal of the CNS. The journal has made its way into cyberspace and is unfettered by the constraints of paper or post. The reach of the journal is now theoretically infinite. Manuscript contributions reflect the international base of the CNS members and its international readership. Not surprisingly the members of the editorial board also represent the internationalism of the CNS.

Other longstanding initiatives include the World Directory of Neurosurgeons; the CNS has been the “census-taker” to the world’s neurosurgeons and provides the repository of record for neurosurgical contact information. Given cybertrends this may soon morph into a Neurosurgical “Facebook.”

The Federation of International Education in Neurological Surgery (FIENS) was founded in 1969 through the auspices of the CNS, supported by other American neurosurgical societies. Its mission is to promote global neurosurgical education and services. FIENS volunteer neurosurgeons and personnel spend months on-site teaching neurosurgeons and trainees. FIENS remains an autonomous volunteer organization.

Given the history of the CNS international involvement and the present network of activities, it is pertinent to ask, what next? The answer of course is there is plenty left undone. Currently, there are the CNS assets that are yet to be fully realized in the international sphere. There is the CNS University of Neurosurgery, a cyber repository of the CNS knowledge for education capable of providing long-distance education to neurosurgeons everywhere, anytime. Because it is electronic and internet-based, text, images, video, podcast and interactivity are all feasible at marginal cost. The promise of telemedicine can be fully realized from this platform.

There is also the matter of the technical skills gap. More neurosurgeons need to be trained to address the critical shortage of neurosurgeons in many regions of the world. A closely related matter is that of standardization, certification, practice development and monitoring to ensure that quality care is available and delivered everywhere.

Finally, there is the matter of resource deficiencies. Some nations have more than they need, others lack what they need. Between these extremes is the potential for bridge building to equilibrate resource needs to serve patients that could benefit.

While it is true that these goals are attainable, few would agree we are there just yet. So the CNS must continue its tradition of international involvement guided by the apt words of Mark Twain.
This patient is a 21-year-old male with psychiatric history who attempted suicide by driving pen casings into his eyes. He presented with bilateral loss of light perception but was otherwise nonfocal. These axial (Figure 1), coronal (Figures 2a and b), and sagittal (Figure 3) CT images show tubular foreign bodies (pen casings) oriented in anteroposterior planes extending from the orbital apices, through the medial aspects of the superior orbital fissures, through the medial aspects of the middle cranial fossae (parasellar), and passing just lateral to the brainstem bilaterally (perimesencephalic cisterns). The objects terminated in the most anterior aspects of the upper brachium ponti bilaterally, where there was a small amount of associated intraparenchymal hemorrhage. The patient underwent transorbital approaches to remove the foreign bodies as the patient had what was determined to be irrevocable bilateral vision loss. He was transferred to the psychiatry service two weeks later.